

Athletic Sports Packet for Competitive Sports
ALL sports including NON-LHSAA sanctioned

An Athlete will NOT be permitted to tryout until all documentation has been turned in and processed (allow three days). Name of the athlete will be posted on bulletin board by the Athletics Director's classroom. **Note: this process is to determine eligibility – it does not mean that the interested athlete is member of the team.**

Athletic Checklist of Documentation to turn in

- _____ Information Sheet
- _____ Parental Permission Form
- _____ CPSB Authorization for treatment and Waiver of Liability
- _____ CPSB Acknowledgement of Risk
- _____ LHSAA Substance Abuse/Misuse Contract and Consent Form
- _____ LHSAA Parent and Student-Athlete Concussion Statement
- _____ Birth Certificate – if athlete participated last year, do not include
- _____ Copy of Insurance Card
- _____ Medical ****
- _____ Turn in by due date (TBA) to Athletic Director

Medical Information****

CMHS, through the Willis-Knighton Hospital System (WK), provides **free medical** in May for athletes wishing to participate in the next school year's sports. **THIS SHALL BE THE ONLY FREE PHYSICAL.** This invitation is extended to **incoming freshman**

- Place and time shall be announced on website under athletics
- Complete and sign all pertinent information of the medical form prior to going to WK.

After the May date, it shall be the responsibility of the athlete to get his/her physical examination. The medical form shall be turned in to the Athletic Director by the end of the first week coming back from the summer break.

Information Sheet

Name (Last, first) _____

Birth Date _____

Grade _____

Father's Name, phone, and email _____

Mother's Name, phones, and email _____

Person(s) with whom child lives _____

Person to contact, other than
Parent, in case of emergency,
If parent cannot be reached _____

Sports (please check only the sports that you are interested in participating)

Summer/Fall

___ Cross Country

___ Swimming

___ Volleyball (girls)

Fall/Winter

___ Archery

___ Soccer

___ Wrestling (boys)

Winter/Spring

___ Golf

___ Gymnastics

___ Lacrosse

___ Softball (girls)

___ Tennis

___ Track & Field

Louisiana High School Athletic Association

Athletic Participation/Parental Permission Form

This form must be completed and signed each year prior to a student's participation in an athletic contest and shall be kept on file with the school. This form is subject to inspection by the LHSAA Rules Compliance Team.

PART I: To be completed and signed by student-athlete (Please Print)

Name: (Last, First, Middle) _____ School Year: _____

Home Address: _____ Parents' Home Address: _____

City: _____ Zip: _____ City: _____ Zip: _____

Date of Birth: _____ Date of Last Physical Exam: _____

I entered ninth grade in _____ (month and year). Last semester/year I attended _____ School.

I certify the preceding information is correct, I have read the summary of LHSAA eligibility rules below and I am in compliance with these standards.

Date: _____ Student's Signature: _____

Telephone No: _____

ARE YOU ELIGIBLE?

As a student athlete in an LHSAA school, you must meet the following rules to be eligible for interscholastic athletic competition:

<u>RULE</u>	<u>COMMENTS</u>
BONA FIDE STUDENT	You must be counted as a student on the daily attendance records at your school. Attendance in one class makes you a student at that school.
ENROLLMENT	You must attend class during the first 11 school days of the first semester or you will be ineligible for the first 30 school days.
AGE	You cannot become 19 years of age prior to September 1 of this year.
PROOF OF AGE	You must provide legal proof of age, which meets the provisions of the LHSAA handbook, to your school administrator to be kept on file at school.
CONSECUTIVE SEMESTERS	Once you enter the ninth grade, you have eight consecutive semesters to play athletics. (EXCEPTION: Hold-Back Repeat Student – See Rule 1.31.9 of the LHSAA handbook)
SCHOLASTIC	For regular education high school students at the end of the first semester you must pass at least six subjects in all subjects taken. At the end of the year and prior to the next school year, you must have earned at least six units with an overall "C" average as determined by the LEA in all units taken. All seniors must take at least four (4) subjects each semester. Special education students must consult the school principal, athletic director, or coach for scholastic information.
RESIDENCE AND SCHOOL TRANSFERS	Upon entering high school for the first time, a student shall have the choice to attend any member school located in the parish in which the student resides with his/her parent(s)/ guardian(s) or any other household with whom the student has been residing for the past calendar year and be immediately eligible unless an applicable exception applies. A transfer to another member school in the same parish will render the student ineligible for one calendar year.

(OVER)

- UNDUE INFLUENCE** If you have been recruited to the school for athletic purposes, you will remain ineligible as long as you attend that school.
- AMATEUR** You cannot play high school athletics if you lose your amateur status.
- INDEPENDENT TEAM** In certain sports you cannot play on a school team and an independent team during the same sport season.
- MEDICAL EXAMINATION** You must annually pass a physical examination given by a licensed physician/nurse practitioner that is in collaboration with a licensed physician or a licensed physician's assistant under the supervision of a licensed physician and complete an LHSAA Medical History Evaluation form prior to participating.
- ATHLETIC PARTICIPATION/
PARENTAL PERMISSION FORM** A school shall be required to have this form completed and signed every year prior to a student's participation in LHSAA athletics at the school.
- SUBSTANCE ABUSE/MISUSE
CONTRACT & CONSENT FORM** A school shall only be required to have this form completed and signed prior to the first time a student participates in LHSAA athletics at the school.
- SUSPENDED AND
INELIGIBLE STUDENTS** Cannot participate in any interscholastic contest on any team at any school at any level.

LHSAA ELIGIBILITY RULES APPLY TO STUDENT ATHLETES ON ALL TEAMS AT ALL LEVELS OF PLAY AT ALL LHSAA SCHOOLS

Eligibility to participate in interscholastic athletics is a privilege you earn by meeting standards outlined on this form and other regulations and policies set by the LHSAA and your school. If you have questions or do not fully understand an eligibility rule, check with your principal, athletic director or coach. By following the intent and spirit of the rules, you can help prevent violations which may penalize you, your team and/or your school.

ONE INELIGIBLE STUDENT MAY DISQUALIFY YOUR WHOLE TEAM – KNOW YOUR ELIGIBILITY RULES

PART II – PARENTAL PERMISSION - To be completed and signed by parent

I have read and reviewed the general requirements for high school athletic eligibility on this form and have discussed these requirements with my student athlete. I understand additional questions /explanations and specific circumstances should be directed to my student's principal; athletic director or coach.

I certify the parents' home address, on the reverse, is my sole bona fide residence and will notify the school principal immediately of any change in residence, since such a move may alter the eligibility status of my student athlete. All other information on the reverse is also accurate and current.

I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/ athletic director/principal of his/her school. Additionally, I give the LHSAA or it representative(s) permission to review my child's scholastic records and all required eligibility forms.

If the medical status of my child changes in any significant manner after he/she passes his/her physical examination, I will notify his/her principal of the change immediately.

I hereby give my consent and approval for the student named on this form to participate in any of the following LHSAA sports:

- | | | |
|---------------|--------------|-----------------|
| BASEBALL | GOLF | SWIMMING |
| BASKETBALL | GYMNASTICS | TENNIS |
| BOWLING | POWERLIFTING | TRACK AND FIELD |
| CROSS COUNTRY | SOCCER | VOLLEYBALL |
| FOOTBALL | SOFTBALL | WRESTLING |

Date: _____ Parent's Signature: _____

(Print Name) _____

Telephone No: () _____

LHSAA SUBSTANCE ABUSE/MISUSE CONTRACT AND CONSENT FORM

This form must be completed and signed and kept on file with the school and is subject to inspection by the LHSAA Rules Compliance Team.

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As an LHSAA athlete, I, _____, agree to avoid the abuse or misuse of legal or illegal substances, including anabolic steroids and other performance enhancing drugs. I hereby grant permission to be tested for substance abuse/misuse as a participant in any LHSAA sports program. I furthermore agree to cooperate by providing a urine or hair specimen for testing upon the request of my principal. I understand that should my specimen indicate the abuse or misuse of legal or illegal substances, I will be subject to action specified in my School Drug Policy for Student Athletes.

*

I, _____, parent/guardian of the undersigned student-athlete, individually, and on behalf of my child, do hereby grant permission for and consent to said child being tested for substance abuse/misuse in accordance with his/her School Drug Policy for Student-Athletes and I understand that if any specimen taken from him/her indicates abuse or misuse of legal or illegal substances, including anabolic steroids and other performance enhancing drugs, he/she will be subject to action specified in the School Drug Policy for Student-Athletes for his/her school.

* Dated: _____

Student-Athlete

* Dated: _____

Parent/Guardian

Notes: Rule 1.10.2 of the LHSAA By-Laws, states that this contract shall remain in effect for the remainder of the student's eligibility. This means the contract only has to be signed once by both the student and his/her parent or guardian but the terms remain in effect for the student's entire high school career.

According to Rule 1.10.3 of the LHSAA By-Laws, without the signature of the student athlete and his/her parent/guardian, the student is ineligible to participate in interscholastic athletic contests at all levels of play in all LHSAA sports at all LHSAA schools until compliance with Rule 1.10.2 is obtained from both parties.

Any student participating in an interscholastic athletic contest(s) without a properly signed contract shall be classified as an ineligible student and both the student and school shall be penalized according to Rule 1.10.3.

Signature of the LHSAA's contract does not necessarily mean the student athlete will be tested. Federal courts have consistently ruled participation in high school athletics is a privilege, not an educational right.



**AUTHORIZATION FOR TREATMENT AND
WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT**

In consideration for participating in athletic events sponsored by, or in any way involving Caddo Parish School Board or any of its schools, I hereby release, waive, discharge, covenant not to sue and hold harmless the Caddo Parish School Board (CPSB), its members, agents, faculty, staff, administrators, officers, servants, and employees (herein referred to as CPSB) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that I or _____ (student-athlete) may sustain or experience, whether caused by the action or inaction, or the negligence of CPSB, or otherwise, while participating in such activity, or while in, on or upon the premises where the activity is being conducted or in transportation to and from said premises.

To the best of my knowledge, _____ (student-athlete) can fully participate in sports activities. I am fully aware of risks and hazards connected with the activity, and I hereby allow the student-athlete to voluntarily participate in said activity and engage in such activity knowing that the activity may be hazardous. I voluntarily assume full responsibility for any risk of loss, property damage or personal injury, including death, that may be sustained, or any loss or damage to property owned, as a result of the student-athlete being engaged in such an activity, whether caused by the negligence of CPSB or otherwise.

I authorize all medical treatment that may become reasonably necessary as a result of the student-athlete's participation in athletic events. I understand that CPSB is not responsible for any costs related to medical treatment. I am aware that I may elect to purchase voluntary student accident insurance if I choose to do so and I will be responsible for all premiums associated with this coverage.

In signing this release, I acknowledge and represent that I (a) have read the foregoing document, understand it and sign it voluntarily; (b) have received no oral representations, statements or inducements apart from the foregoing written agreement; and (c) am fully competent and the proper person to execute this document.

Signed this _____ day of _____, 20_____.

Student Athlete (Printed Name)

Parent/Guardian (Printed Name)

Date

Parent/Guardian (Signature)

Date



ACKNOWLEDGEMENT OF RISK

There is a risk of injury that comes with participation in athletics. The degree of seriousness or the risk and the type of possible injury varies with the sport or activity. Injuries could possibly range from concussions, broken bones, sprains, or even more serious conditions, such as death. These injuries may occur despite the best possible rules, measures of protection, instruction and coaching.

Having read this form and explained this to my son/daughter,

I, _____ (Print-parent or guardian name), hereby give my consent for my child to participate in athletics at _____ School.

Parent/Guardian (Signature)

Date

Student Athlete (Printed Name)

Date

Student Athlete (Signature)

Date

**Louisiana High School Athletic Association
Parent and Student-Athlete Concussion Statement**

- I understand that it is my responsibility to report all injuries and illnesses to my coach, athletic trainer and/or team physician.
- I have read and understand the Concussion Fact Sheet.

After reading the Concussion Fact Sheet, I am aware of the following information:

Parent Initial	Student Initial	
		A concussion is a brain injury, which I am responsible for reporting to my coach , athletic trainer, or team physician.
		A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance
		You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.
		If I suspect a teammate has a concussion, I am responsible for reporting the injury to my coach, athletic trainer, or team physician.
		I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.
		Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.
		In rare cases, repeat concussions can cause permanent brain damage, and even death.

Signature of Student-Athlete	Date
Printed name of Student-Athlete	
Signature of Parent/Guardian	Date
Printed name of Parent/Guardian	



LHSAA MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed annually, kept on file with the school, & is subject to inspection by the Rules Compliance Team.
Please Print

Name: _____ School: _____ Grade: _____ Date: _____
 Sport(s): _____ Sex: M / F Date of Birth: _____ Age: _____ Cell Phone: _____
 Home Address: _____ City: _____ State: _____ Zip Code: _____ Home Phone: _____
 Parent / Guardian: _____ Employer: _____ Work Phone: _____

FAMILY MEDICAL HISTORY: Has any member of your family under age 50 had these conditions?

Yes No Condition <input type="checkbox"/> <input type="checkbox"/> Heart Attack/Disease <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Diabetes	Whom _____ _____ _____	Yes No Condition <input type="checkbox"/> <input type="checkbox"/> Sudden Death <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Trait/Anemia	Whom _____ _____ _____	Yes No Condition <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> <input type="checkbox"/> Epilepsy	Whom _____ _____ _____
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ATHLETE'S ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?

Yes No Condition <input type="checkbox"/> <input type="checkbox"/> Head Injury / Concussion <input type="checkbox"/> <input type="checkbox"/> Elbow L / R <input type="checkbox"/> <input type="checkbox"/> Hip L / R <input type="checkbox"/> <input type="checkbox"/> Lower Leg L / R <input type="checkbox"/> <input type="checkbox"/> Foot L / R <input type="checkbox"/> <input type="checkbox"/> Chest	Date _____ _____ _____ _____ _____	Yes No Condition <input type="checkbox"/> <input type="checkbox"/> Neck Injury / Stinger <input type="checkbox"/> <input type="checkbox"/> Arm / Wrist / Hand L / R <input type="checkbox"/> <input type="checkbox"/> Thigh L / R <input type="checkbox"/> <input type="checkbox"/> Chronic Shin Splints <input type="checkbox"/> <input type="checkbox"/> Severe Muscle Strain	Date _____ _____ _____ _____ _____	Yes No Condition <input type="checkbox"/> <input type="checkbox"/> Shoulder L / R <input type="checkbox"/> <input type="checkbox"/> Back <input type="checkbox"/> <input type="checkbox"/> Knee L / R <input type="checkbox"/> <input type="checkbox"/> Ankle L / R <input type="checkbox"/> <input type="checkbox"/> Pinched Nerve	Date _____ _____ _____ _____ _____
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Previous Surgeries: _____

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?

Yes No Condition <input type="checkbox"/> <input type="checkbox"/> Heart Murmur / Chest Pain / Tightness <input type="checkbox"/> <input type="checkbox"/> Seizures <input type="checkbox"/> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> <input type="checkbox"/> Single Testicle <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Dizzy / Fainting <input type="checkbox"/> <input type="checkbox"/> Organ Loss (kidney, spleen, etc) <input type="checkbox"/> <input type="checkbox"/> Surgery <input type="checkbox"/> <input type="checkbox"/> Medications	Yes No Condition <input type="checkbox"/> <input type="checkbox"/> Asthma / Prescribed Inhaler <input type="checkbox"/> <input type="checkbox"/> Shortness of breath / Coughing <input type="checkbox"/> <input type="checkbox"/> Hemia <input type="checkbox"/> <input type="checkbox"/> Knocked out / Concussion <input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Liver Disease <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Prescribed EPI PEN	Yes No Condition <input type="checkbox"/> <input type="checkbox"/> Menstrual irregularities: Last Cycle: _____ <input type="checkbox"/> <input type="checkbox"/> Rapid weight loss / gain <input type="checkbox"/> <input type="checkbox"/> Take supplements/vitamins <input type="checkbox"/> <input type="checkbox"/> Heat related problems <input type="checkbox"/> <input type="checkbox"/> Recent Mononucleosis <input type="checkbox"/> <input type="checkbox"/> Enlarged Spleen <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Trait/Anemia <input type="checkbox"/> <input type="checkbox"/> Overnight in hospital <input type="checkbox"/> <input type="checkbox"/> Allergies (Food, Drugs)
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List Dates for: Last Tetanus Shot: _____ Measles Immunization: _____ Meningitis Vaccine: _____

PARENTS' WAIVER FORM

To the best of our knowledge, we have given true & accurate information & hereby grant permission for the physical screening evaluation. We understand the evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. We further understand that if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the team volunteer health-care provider and/or employer under Louisiana law.

This waiver, executed on the date below by the undersigned medical doctor, osteopathic doctor, nurse practitioner or physician's assistant and parent of the student athlete named above, is done so in compliance with Louisiana law with the full understanding that there shall be no cause of action for any loss or damage caused by any act or omission related to the health care services if rendered voluntarily and without expectation of payment herein unless such loss or damage was caused by gross negligence. Additionally,

1. If, in the judgment of a school representative, the named student-athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary.....Yes No
2. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately.....Yes No
3. I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school.....Yes No
4. By my signature below, I am agreeing to allow my child's medical history/exam form and all eligibility forms to be reviewed by the LHSAA or its Representative(s).....Yes No

Date Signed by Parent _____  Signature of Parent _____ Typed or Printed Name of Parent _____

II. COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPATHIC DR. (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

Height _____	Weight _____	Blood Pressure _____	Pulse _____
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GENERAL MEDICAL EXAM : Norm Abnl ENT <input type="checkbox"/> <input type="checkbox"/> Lungs <input type="checkbox"/> <input type="checkbox"/> Heart <input type="checkbox"/> <input type="checkbox"/> Abdomen <input type="checkbox"/> <input type="checkbox"/> Skin <input type="checkbox"/> <input type="checkbox"/> Hernia <input type="checkbox"/> <input type="checkbox"/> (if Needed)	OPTIONAL EXAMS: VISION: L: _____ R: _____ Corrected: _____ DENTAL: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	ORTHOPAEDIC EXAM : Norm Abnl I. Spine / Neck Cervical <input type="checkbox"/> <input type="checkbox"/> Thoracic <input type="checkbox"/> <input type="checkbox"/> Lumbar <input type="checkbox"/> <input type="checkbox"/> II. Upper Extremity Shoulder <input type="checkbox"/> <input type="checkbox"/> Elbow <input type="checkbox"/> <input type="checkbox"/> Wrist <input type="checkbox"/> <input type="checkbox"/> Hand / Fingers III. Lower Extremity Hip <input type="checkbox"/> <input type="checkbox"/> Knee <input type="checkbox"/> <input type="checkbox"/> Ankle <input type="checkbox"/> <input type="checkbox"/>
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COMMENTS: _____

From this limited screening I see no reason why this student cannot participate in athletics.

- [] Student is cleared
 [] Cleared after further evaluation and treatment for: _____
 [] Not cleared for: ___contact ___non-contact

Printed Name of MD, DO, APRN or PA _____ Signature of MD, DO, APRN or PA _____ Date of Medical Examination _____

This physical expires one year on the last day of the month that it was signed and dated by the MD, DO, APRN or PA.