# Boyet Junior High School

59295 Rebel Drive
Slidell, Louisiana 70461
Phone (985) 643-3775
Fax (985} 649-9470

John Priola, Jr.
Principal

Marc Merriman
Assistant Principal

I hereby give permission for my child, _____ to attend and participate in the athletic events as herein described.

Event: Baseball Tryouts with Season to follow
Coach/Sponsor/Teacher Walsh
Time/Date: Jan 18 + 19 4:30-6:30 Fritchie Park
Location: Boyet and other baseball Parks
Means of Transportation _____

(A) Private vehicle *See note below.
B. St. Tammany Parish School Bus/Other (Please Describe)
_____

Activity Approval _____ (For Administrative Use Only)
Date: _____

Before signing this form, please note that your signature will serve as a declaration that you have read, understood and agreed to the following:

A. You must provide the evidence of possession of insurance before a student will be allowed to tryout or participate in any athletic activity, dance team, or cheerleading squad.
B. You must provide evidence of a current physical for your child: a current physical provided during the current school term (June - May 31). This must be done before a student will be allowed to tryout or participate in any athletic activity, dance team, or cheerleading squad
C. Your child must meet all athletic eligibility, academic, and behavioral guidelines.
D. You must have completed an Emergency Card to be filed with the sponsor/coach of the activity.
E. You must secure your child within fifteen (15) minutes following the conclusion of the activity.
F. I give permission for Boyet personnel and/or chaperones to seek/administer emergency medical aid for/to my child if they deem it necessary.
G. I will not hold St. Tarnmany Parish School Board, Boyet Jr. High, Boyet administrators and /or faculty and /or the representatives thereof responsible in the event of any accident during any and all aspects of the athletic activity.

Note: Before signing this form, please be certain that all your questions or concerns are addressed; you may contact the school at 643-3775.
Note: No ten (10)-passenger vans/vehicles may be used to transport student to school activities.
Note: According to school board policy, owner of private vehicles that are used for school activities are primary insurance carriers.

PARENT/GUARDIAN.SIGNATURE AND DATE

_____

# ATHLETIC EMERGENCY SHEET

STUDENT: _____ I.D.#_____
DATE OF BIRTH: _____

PARENT/GUARDIAN_____

TELEPHONE_____WORK PHONE_____

Who will assume temporary care and responsibility for your child in the event of emergency:

1. NAME_____PHONE:_____
2. NAME_____PHONE:_____
3. NAME_____PHONE:_____

LIST ANY ALLERGIES OR MEDICAL CONDITIONS:

1.
2.
3.
4.
5.

**********

PROOF OF INSURANCE

1. Company: _____
2. Policy/Company/Card Number:_____
3. Expiration Date:_____

To Whom It May Concern: I give permission for Boyet Junior High School personnel to seek/administer emergency medical aid for my child as they deem necessary.

_____
Parent/Guardian Signature

# SCHOOL WAIVER FORM
# EXTRACURRICULAR ACTIVITES

**The St. Tammany Parish School Board, its employees, agents and insurers have no liability, and accepts no liability for injuries or accidents occurring to students during their participation in interscholastic athletics or sports and related extracurricular teams or activities. The student and parent(s)/guardian(s) assume any and all risks, including without limitation risk of injury and risk of incurring medical expenses associated with the participation by the student.**

Student's Name _____ Sports/Activities _____ Sex M F

School _____ Grade _____ Age_____ Date of Birth___/___/___

Parent's/Guardian's Name _____

Father's/Guardian's SS# XXX-XX_____ Mother's/Guardian's SS# XXX-XX_____

Work Address _____

Phone Number (  )_____

Home Address _____

Phone Number (  )_____

Another Person to Contact _____

Relationship _____ Phone Number (  ) _____

Insurance Company _____

Policy Number and/or Group Numbers _____

ALLERGIES _____

Parent's Signature _____ Student's Signature _____
(if over age 18)

Date _____ Date _____

**IMPORTANT NOTICE** – It is the policy of the St. Tammany Parish School Board that **ALL** athletes participating in our school sports programs MUST HAVE EITHER MEDICAL OR ACCIDENT INSURANCE IN ORDER TO PARTICIPATE! Please be sure to provide that information on this form. This information also becomes important in case of injury or illness and we are unable to immediately contact parents/guardians

## 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 | Whom | Yes | No | Condition | Whom | Yes | No | Condition | Whom |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Heart Attack/Disease | | ☐ | ☐ | Sudden Death | | ☐ | ☐ | Arthritis | |
| ☐ | ☐ | Stroke | | ☐ | ☐ | High Blood Pressure | | ☐ | ☐ | Kidney Disease | |
| ☐ | ☐ | Diabetes | | ☐ | ☐ | Sickle Cell Trait/Anemia | | ☐ | ☐ | Epilepsy | |

**ATHLETE'S ORTHOPAEDIC HISTORY:** Has the athlete had any of the following injuries?

| Yes | No | Condition | Date | Yes | No | Condition | Date | Yes | No | Condition | Date |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Head Injury / Concussion | | ☐ | ☐ | Neck Injury / Stinger | | ☐ | ☐ | Shoulder L / R | |
| ☐ | ☐ | Elbow L / R | | ☐ | ☐ | Arm / Wrist / Hand L / R | | ☐ | ☐ | Back | |
| ☐ | ☐ | Hip L / R | | ☐ | ☐ | Thigh L / R | | ☐ | ☐ | Knee L / R | |
| ☐ | ☐ | Lower Leg L / R | | ☐ | ☐ | Chronic Shin Splints | | ☐ | ☐ | Ankle L / R | |
| ☐ | ☐ | Foot L / R | | ☐ | ☐ | Severe Muscle Strain | | ☐ | ☐ | Pinched Nerve | |
| ☐ | ☐ | Chest | | Previous Surgeries: | | | | | | | |

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

| Yes | No | Condition | Yes | No | Condition | Yes | No | Condition |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Heart Murmur / Chest Pain / Tightness | ☐ | ☐ | Asthma / Prescribed Inhaler | ☐ | ☐ | Menstrual irregularities: Last Cycle:_____ |
| ☐ | ☐ | Seizures | ☐ | ☐ | Shortness of breath / Coughing | ☐ | ☐ | Rapid weight loss / gain |
| ☐ | ☐ | Kidney Disease | ☐ | ☐ | Hernia | ☐ | ☐ | Take supplements/vitamins |
| ☐ | ☐ | Irregular Heartbeat | ☐ | ☐ | Knocked out / Concussion | ☐ | ☐ | Heat related problems |
| ☐ | ☐ | Single Testicle | ☐ | ☐ | Heart Disease | ☐ | ☐ | Recent Mononucleosi |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Diabetes | ☐ | ☐ | Enlarged Spleen |
| ☐ | ☐ | Dizzy / Fainting | ☐ | ☐ | Liver Disease | ☐ | ☐ | Sickle Cell Trait/Anemia |
| ☐ | ☐ | Organ Loss (kidney, spleen, etc) | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Overnight in hospital |
| ☐ | ☐ | Surgery | ☐ | ☐ | Prescribed EPI PEN | ☐ | ☐ | Allergies (Food, Drugs)_____ |
| ☐ | ☐ | Medications_____ | | | | | | |

List Dates for: Last Tetanus Shot:_____ Measles Immunization:_____ Meningitis Vaccine:_____

**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.

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

This waiver, executed this ____ day of _____, 20___, by _____, M.D., D.O., APRN or PA and _____, student athlete, is executed 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.

Typed or Printed Name of Student Athlete | 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_____

**GENERAL MEDICAL EXAM:**

| | Norm | Abnl |
|---|---|---|
| ENT | ☐ | ☐ |
| Lungs | ☐ | ☐ |
| Heart | ☐ | ☐ |
| Abdomen | ☐ | ☐ |
| Skin | ☐ | ☐ |
| Hernia (if Needed) | ☐ | ☐ |

COMMENTS: _____

**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 | ☐ | ☐ |
| | Thoracic | ☐ | ☐ |
| | Lumbar | ☐ | ☐ |
| II. | Upper Extremity | | |
| | Shoulder | ☐ | ☐ |
| | Elbow | ☐ | ☐ |
| | Wrist | ☐ | ☐ |
| | Hand / Fingers | ☐ | ☐ |
| III. | Lower Extremity | | |
| | Hip | ☐ | ☐ |
| | Knee | ☐ | ☐ |
| | Ankle | ☐ | ☐ |

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

* 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.