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: Girls basketball tryouts with season to follow.
Coach/Sponsor/Teacher Shoultz
Time/Date: Oct 3-5 4-5:30
Location: Boyet and other schools.
Means of Transportation _____

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

Activity Approval Jeremy Jackson (For Administrative Use Only)
Date: 9/12/18

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)	☐	☐

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	☐	☐

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

* 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