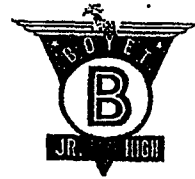




Boy et Junior High School



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: Boys Volleyball tryouts with season to follow
Coach/Sponsor/Teacher Cochran
Time/Date: March 6+7 4-5:30 with season to follow.
Location: Boy et and other schools
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 Boy et 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. Tammany Parish School Board, Boy et Jr. High, Boy et 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
<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Disease	_____	<input type="checkbox"/> <input type="checkbox"/> Sudden Death	_____
<input type="checkbox"/> <input type="checkbox"/> Stroke	_____	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> <input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Trait/Anemia	_____
		<input type="checkbox"/> <input type="checkbox"/> Arthritis	_____
		<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	_____
		<input type="checkbox"/> <input type="checkbox"/> Epilepsy	_____

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

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

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

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

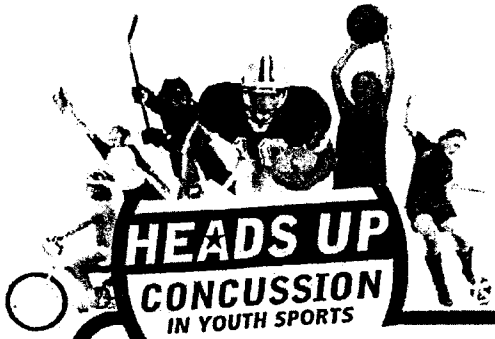
<p>GENERAL MEDICAL EXAM :</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 30%;"></td> <td style="width: 10%;">Norm</td> <td style="width: 10%;">Abnl</td> </tr> <tr> <td>ENT</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Abdomen</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Skin</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hernia (if Needed)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		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 (if Needed)	<input type="checkbox"/>	<input type="checkbox"/>	<p>OPTIONAL EXAMS:</p> <p>VISION: L: _____ R: _____ Corrected: _____</p> <p>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</p>	<p>ORTHOPAEDIC EXAM</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 70%;"></td> <td style="width: 10%;">Norm</td> <td style="width: 20%;">Abnl</td> </tr> <tr> <td>I. Spine / Neck</td> <td></td> <td></td> </tr> <tr> <td> Cervical</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td> Thoracic</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td> Lumbar</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>II. Upper Extremity</td> <td></td> <td></td> </tr> <tr> <td> Shoulder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td> Elbow</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td> Wrist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td> Hand / Fingers</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>III. Lower Extremity</td> <td></td> <td></td> </tr> <tr> <td> Hip</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td> Knee</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td> Ankle</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		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	<input type="checkbox"/>	<input type="checkbox"/>	III. Lower Extremity			Hip	<input type="checkbox"/>	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>	Ankle	<input type="checkbox"/>	<input type="checkbox"/>
	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 (if Needed)	<input type="checkbox"/>	<input type="checkbox"/>																																																															
	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	<input type="checkbox"/>	<input type="checkbox"/>																																																															
III. Lower Extremity																																																																	
Hip	<input type="checkbox"/>	<input type="checkbox"/>																																																															
Knee	<input type="checkbox"/>	<input type="checkbox"/>																																																															
Ankle	<input type="checkbox"/>	<input type="checkbox"/>																																																															

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.



A Fact Sheet for **ATHLETES**

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a bump or blow to the head
- Can change the way your brain normally works
- Can occur during practices or games in any sport
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged"

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not "feel right"

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach if one of your teammates might have a concussion.

- **Get a medical check up.** A doctor or health care professional can tell you if you have a concussion and when you are OK to return to play.
- **Give yourself time to get better.** If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.

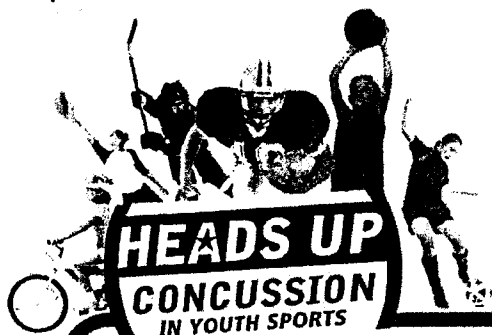
HOW CAN I PREVENT A CONCUSSION?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Use the proper sports equipment, including personal protective equipment (such as helmets, padding, shin guards, and eye and mouth guards). In order for equipment to protect you, it must be:

- > The right equipment for the game, position, or activity
- > Worn correctly and fit well
- > Used every time you play

It's better to miss one game than the whole season.



A Fact Sheet for PARENTS

WHAT IS A CONCUSSION?

A concussion is a brain injury. Concussions are caused by a bump or blow to the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

You can’t see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

Signs Observed by Parents or Guardians

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Can’t recall events prior to hit or fall
- Can’t recall events after hit or fall

Symptoms Reported by Athlete

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Does not “feel right”

HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION?

Every sport is different, but there are steps your children can take to protect themselves from concussion.

- Ensure that they follow their coach’s rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity (such as helmets, padding, shin guards, and eye and mouth guards). Protective equipment should fit properly, be well maintained, and be worn consistently and correctly.
- Learn the signs and symptoms of a concussion.

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. **Seek medical attention right away.** A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to sports.
2. **Keep your child out of play.** Concussions take time to heal. Don’t let your child return to play until a health care professional says it’s OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.
3. **Tell your child’s coach about any recent concussion.** Coaches should know if your child had a recent concussion in ANY sport. Your child’s coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

It’s better to miss one game than the whole season.

What are the signs and symptoms of a concussion?

SIGNS OBSERVED BY PARENTS, FRIENDS, TEACHERS OR COACHES

- Appears dazed or stunned
- Is confused about what to do
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness
- Shows behavior or personality changes
- Can't recall events prior to hit
- Can't recall events after hit

SYMPTOMS REPORTED BY ATHLETE

- Headache
- Nausea
- Balance problems or dizziness
- Double or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish
- Feeling foggy or groggy
- Concentration or memory problems
- Confusion

What should I do if I think my child has had a concussion?

If an athlete is suspected of having a concussion, he or she must be immediately removed from play, be it a game or practice. Continuing to participate in physical activity after a concussion can lead to worsening concussion symptoms, increased risk for further injury, and even death. Parents and coaches are not expected to be able to "diagnose" a concussion, as that is the job of a medical professional. However, you must be aware of the signs and symptoms of a concussion and if you are suspicious, then your child must stop playing:

When in doubt, sit them out!

All athletes who sustain a concussion need to be evaluated by a health care professional who is familiar with sports concussions. You should call your child's physician and explain what has happened and follow your physician's instructions. If your child is vomiting, has a severe headache, is having difficulty staying awake or answering simple questions he or she should be taken to the emergency department immediately.