IPRD MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed annually Please Print

Name:		Grade:Date:
Sport(s):	Sex: M / F Date of B	Sirth:Age:Cell Phone:
		e:Zip Code:Home Phone:
Parent / Guardian:		Work Phone:
FAMILY MEDICAL HISTORY: Has any me	ember of your family under age 50 had these condi	litions?
Yes No Condition Whom □ Heart Attack/Disease □ Stroke □ Diabetes	Yes No Condition W Image: Display the second seco	Yes No Condition Whom □ □ Arthritis
Yes No Condition Date □ Head Injury / Concussion	Image: Severe Muscle Strain Image: Severe Muscle Strain	Date Yes No Condition Date □ Shoulder L / R
ATHLETE MEDICAL HISTORY: Has the a	athlete had any of these conditions?	
Yes No Condition □ Heart Murmur / Chest Pain / Tightr □ Seizures □ Kidney Disease □ Irregular Heartbeat □ Single Testicle □ High Blood Pressure □ Dizzy / Fainting □ Organ Loss (kidney, spleen, etc) □ Surgery □ Medications	 Shortness of breath / Coughin Hernia Knocked out / Concussion Heart Disease Diabetes Liver Disease Tuberculosis Prescribed EPI PEN 	Yes No Condition Image: Condition Image: C
List Dates for: Last Tetanus Shot:		Meningitis Vaccine:

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 an IPRD 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 director 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/rep of his/her league	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 IPRD 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			
GENERAL MED			OPTIONAL EX	(AMS:	ORTHOPAEDIC EX		
	Norm	Abnl	VISION:			Norm	Abnl
ENT			L:R:	Corrected:	I. Spine / Neck	_	_
Lungs					Cervical		
Heart			DENTAL:		Thoracic		
Abdomen			1 2 3 4 5 6	7 8 9 10 11 12 13 14 15 16	Lumbar		
Skin			31 30 29 28 27	26 25 24 23 22 21 20 19 18 17	II. Upper Extremity	v	
Hernia	L L				Shoulder	í 🗆	
(if Needed)		<u>ц</u>			Elbow		
	COMMEN	NTS:			Wrist		
					Hand / Fingers	—	_
					III. Lower Extremit	v	
					Hip	' □	
From this limite	d screening	I see no reas	son why this student canno	ot participate in athletics.	Knee		
	•						
[] Student is o					Ankle		
[] Cleared after	er further eva	aluation 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 13 months from the date it was signed and dated by the MD, DO, APRN or PA.