TO: Parents of students participating in athletics in the East Baton Rouge Parish School system

FROM: Andrew Davis

DATE: August 8, 2016

SUBJECT: East Baton Rouge Parish School Board Student Insurance Program

Parents,

This memo serves as notice of the East Baton Rouge Parish School Board’s Student Insurance Program.

JGA/ LA R.S. Ann. §17:81 provides:

The East Baton Rouge Parish School Board shall make available student accident insurance for purchase for students attending East Baton Rouge Parish public schools. An application form provided by the insurance carrier shall be sent home with students during the first week of school. The schools shall not be liable for any premium payment. Claim forms shall be furnished by the insurance carrier and copies shall be available in the school office.

EXTRACURRICULAR ACTIVITIES INSURANCE COVERAGE

All students participating on any interscholastic athletic team, including varsity football, junior varsity football, junior high football, all basketball, baseball, track, swimming, any other competitive sport for boys or girls, and cheerleading squads, shall be required to purchase student accident insurance or shall be required to sign a form declining student insurance and acknowledging full responsibility for any expenses associated with any injury suffered by the student as a result of participating in any interscholastic athletic program. The insurance form must be presented to the school before the student shall be permitted to participate in any athletic activity.

Andrew Davis
Director of Risk Management
ATHLETE’S NAME: ___________________________________________ Date: __________________

SEX: Male or Female   AGE: ___________   D.O.B. __/__/____   Grade: ___________
(Circle One)

PARENTAL CONSENT FORM FOR ATHLETICS - 2021-2022

I have been informed that my son/daughter desires to participate in athletics this year, and he/she has my consent to do so. In signing this form, I understand that he/she will participate in sport activities where there is the possibility of injury, ranging from minor to severe. I also understand that he/she must meet certain eligibility requirements set by the Junior Recreation Athletic Association and the North Baton Rouge Parish School Board. I am also willing to abide by those rules as administered through the athletic association and the school staff.

I hereby give my consent for the above-named student to represent ___________________________ Middle School in his/her sport and for him/her to accompany the team on athletic trips. This may include games, practices and scrimmages.

I understand my child must submit to their coach a LHSAA Medical History (Physical) Form (dated July 1, 2021 to present for the 2021-2022 school year). A copy of the physical exam will be good for all sports during the 2021-2022 year and will be kept on file in the designated location. THE MEDICAL EXAM MUST BE ADMINISTERED AND SIGNED BY A MEDICAL DOCTOR OR LICENSED NURSE PRACTITIONER BEFORE MY CHILD IS ALLOWED TO PRACTICE OR COMPETE.

The student must have health insurance before being eligible to participate in middle school athletics. A copy of the student’s insurance card must be given to the coach and placed in my child’s folder.

The school system offers (for purchase) the voluntary student accident insurance that will cover your child for athletics in case of an injury. A Declaration Declining Student Accident Insurance Form must be signed if you do not wish to purchase this voluntary student accident insurance. Go to www.studentinsurance-kk.com; under parents, click Purchase Coverage; type in East Baton Rouge and enter LA; click View Insurance Products/Purchase Coverage; click Buy Online Now with a Debit or Credit Card or Print and Pay by Check.

Parent/Legal Guardian’s Signature: ___________________________________________

DECLARATION DECLINING STUDENT ACCIDENT INSURANCE - 2021-2022

(Parent/Guardian) (Child’s Name) hereby decline the voluntary student insurance made available for purchase through the East Baton Rouge Parish School Board.

I also hereby acknowledge that if my child is participating in any middle school interscholastic athletic program, he or she, in accordance with the East Baton Rouge Parish School Board’s policy, CANNOT participate without insurance.

Additionally, whether my child is participating in any high school or middle school interscholastic athletic program, I hereby acknowledge full responsibility for any expenses associated with any injury suffered by my child as a result of participating in any interscholastic athletic program in the East Baton Rouge Parish School System.

Parent/Legal Guardian’s Signature: ___________________________________________

2
PARTICIPATION WITH AN INDEPENDENT TEAM/ORGANIZED GROUP - 2021-2022

A student shall not be permitted to take part in any branch of athletics not sponsored by the school while he/she is a member of a school team or squad in that same sport. This includes playing or participating with an organized group.

The penalty for violating this rule if it occurs while the student is practicing with an independent team or organized exhibition group, shall be suspension in the sport for the remainder of the school year should said student participate in an athletic contest with the school team after having committed the violation. The penalty for violation of this rule if it occurs while playing with an independent team or organized group will be suspension of one (1) calendar year in that same sport should said student participate in an athletic contest with the school team in that same sport after having committed the violation.

Parent/Legal Guardian’s Signature: ________________________________

PARENTAL/LEGAL GUARDIAN MEDIA CONSENT FORM - 2021-2022

I hereby consent to the use of any photographs/video tape taken of my child by the East Baton Rouge Parish School System or the media for the purpose of advertising or publicizing events, activities, facilities and programs of the East Baton Rouge Parish School System in newspapers, newsletters, website, other publications, television, radio and other communications and advertising media.

By law, the East Baton Rouge Parish School System protects the privacy of the students and is prohibited from releasing students’ personal information.

From time to time representatives of the news media are invited to campus to cover events at our schools. When this happens there is a possibility your child/children may be photographed, videotaped, or interviewed for a news story.

Please mark one of the choices below and return to school.

_____ Yes, I allow my child/children to be identified in any good news district or school publication.

_____ No, I do not want my child/children identified in any good news district or school publication.

Parent/Legal Guardian’s Signature: ________________________________

I have read the and understand the above statements and regulations, and _______ has my permission to take part in athletics at ______________________ Middle School this 2021-2022 school year.

Student’s Name: ___________________________ Student’s Signature: ___________________________

Please Print

Parent’s Name: __________________________ Parent’s signature: ___________________________ Date: ______

Please Print

APPROVED: ___________________________________________

Principal’s Signature
What is a Concussion?
A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head that causes the head and brain to move quickly back and forth. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

Facts about Concussions
1. A concussion is a serious brain injury
2. Concussions can occur without a loss of consciousness or other obvious signs
3. Concussions can occur from blows to the body as well as to the head
4. Concussions can occur in any sport
5. Athletes can still get a concussion even if they are wearing a helmet
6. Recognition and proper response to concussions when they first occur can help prevent further injury or even death.

Symptoms Reported by Athlete:
- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double vision
- Sensitivity to light or noise
- Confusion
- Feeling sluggish, hazy, foggy or groggy
- Just not “feeling right” or is “feeling down”
- Blurry vision
- Concentration or memory problems

Signs Observed by Parents, Friends, Teachers, or Coaches
- Appears dazed or stunned
- Loses Consciousness (even briefly)
- Is confused about what to do
- Moves clumsily
- Forgets plays or instruction
- Answers questions slowly
- Is unsure of game, score, or opponent
- Shows mood, behavior, or personality changes
- Can’t recall events prior to hit or fall
- Can’t recall events after hit or fall

Concussion Danger Signs
- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that get worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Has unusual behavior
- Becomes increasingly confused, restless, or agitated
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

Signs and symptoms of a concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If an athlete reports one or more symptoms of a concussion listed above after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it’s OK to return to play.

Statement of Student Athlete Responsibility
I accept responsibility for reporting all injuries and illnesses to the coach and parent(s) including any signs and symptoms of a Concussion. I have read and understand the above information on concussions.

Student Printed Name ___________________________ Student’s Signature ____________________________

As a parent of the above-mentioned student, I am also aware of the issues concerning concussions as mentioned in this document and agree to adhere to these guidelines.

Parent’s Signature ____________________________ Date ____________________________

FOR more information:
cdc.gov/concussion
1. **Activities and Approximate Dates: (To be completed by the School)**
   For the *(School Name)* Girls/Boys Athletic Events Team to attend middle school Sports Contests from August 2021 to May 15, 2022.

<table>
<thead>
<tr>
<th>Student Name (Please Print)</th>
<th>Student ID Number</th>
<th>School Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **I do hereby grant permission for the following student to attend and participate in the described activities.**

<table>
<thead>
<tr>
<th>Parent or Legal Guardian Name</th>
<th>Legal Relationship</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(Please Print)</em></td>
<td>( ) Parent</td>
<td>_________</td>
<td>_____</td>
</tr>
<tr>
<td></td>
<td>( ) Foster Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>( ) Legal Guardian</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. **AUTHORIZATION TO PROVIDE MEDICAL TREATMENT**
   In the event of any injury sustained in the course of the above activity, school system representatives are authorized to render necessary medical treatment to the student listed above.

   *Signature of Parent or Legal Guardian: ________________________________*

4. **RELEASE OF MEDICAL RECORDS AND REPORTS**
   You or any physician, hospital, clinic or medical care provider are authorized to furnish to the North Baton Rouge Parish School Board, all medical records, information, facts, and particulars which may be requested and to furnish them copies of such.

   This information is to be used for the purposes of evaluating and handling this student’s claim of injury as a result of the accident on the date indicated in Section 5. A photocopy of this form may be accepted with the same authority as the original.

   *Signature of Parent or Legal Guardian: ________________________________*

5. **TO BE COMPLETED BY PHYSICIAN ONLY IN THE EVENT OF INJURY**
   
   **Date of Injury**_________________ **Initial Diagnosis**_________________

   ________________________________________________________________
   ________________________________ _____________________________

   *Signature of Physician or Authorized Representative* ____________________________ *Date* ____________________________

   ________________________________ _____________________________
   Name, Address, and Phone Number of Medical Facility ____________________________ *Date* ____________________________
MEDICAL HISTORY EVALUATION

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

Name: ____________________________ School: ____________________________

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
☐ □ 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
☐ □ 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
☐ □ Heart Murmur / Chest Pain / Tightness _________ ☐ □ Asthma / Precribed 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 Mononucleosis _________
☐ □ 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: ____________

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 DOCTOR, (DO), NURSE PRACTITIONER (APRN) OR PHYSICIAN’S ASSISTANT (PA)

Height ____________ Weight ____________ Blood Pressure ____________ Pulse ____________

GENERAL MEDICAL EXAM:

ENT ☐ □ Norm Abnl
Lungs ☐ □ Norm Abnl
Heart ☐ □ Norm Abnl
Abdomen ☐ □ Norm Abnl
Skin ☐ □ Norm Abnl
Herna ☐ □ Norm Abnl
(If Needed) COMMENTS:

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:

I. Spine / Neck ☐ □ Norm Abnl
Cervical ☐ □ Thoracic ☐ □ Lumbar ☐ □

II. Upper Extremity ☐ □ Norm Abnl
Shoulder ☐ □ Elbow ☐ □ Wrist ☐ □ Hand / Fingers ☐ □

III. Lower Extremity ☐ □ Norm Abnl
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 of Medical Examination ____________________________

This physical is good from July 1, 2021 to June 30, 2022 and must be signed by the MD, DO, APRN, or PA. Revised 5/18