Hammond High Magnet School Athletics
Paperwork Checklist
(*<u>These are the only acceptable forms)</u>*

NO STUDENT WILL BE ALLOWED TO TRY OUT OR PARTICIPATE FOR ANY TEAM WITHOUT THIS PAPERWORK ON FILE

ATHLETE'S NAME_____

Check	Item
	1. COVID-19 Screening form
	2. Current Physical form completely filled out with all proper signatures **FREE North Oaks Physical Day for HAMMOND HIGH is *WEDNESDAY, JUNE 2ND.***
	3. Copy of Birth Certificate (do not need another copy if you were on a team last year)
	4. LHSAA Parent permission form (2 pages)
	5. LHSAA Substance abuse form
	6. North Oaks Drug Screen Form
	7. Concussion Statement signed by parent and student
	8. North Oaks Photo Authorization Release
	9. North Oaks IMPACT Testing Consent
	8. A $30 insurance payment will be due upon making any team (this is a one time payment)
	9. Do you currently live in Hammond High Magnet School Attendance Zone: YES or NO (circle one)

If you have played a sport for the current school year, you do not need to repeat this paperwork. Please let the current coach know what sport you have played this year.

Highschool Sports Medicine Initial COVID-19 Screening Form – Last updated: 5/09/20

ATHLETE NAME: _____ Date of Birth: _____

School: _____ PARENT / GUARDIAN NAME(S):_____

Telephone: (H) _____ (W)_____ (C) _____

Medical History Please check all that apply: Circulatory / Pulmonary Conditions_____ High Blood Pressure _____ Chronic Lung Disease _____ Diabetes _____ Asthma _____ Allergies _____ Compromised immune system conditions _____ Other _____

If checked above please explain: _____

Please complete the remaining information to assess your potential exposure / possession of COVID-19 and other illnesses.

Are you currently free from illness? _____ Yes, _____ No

During your time away from school, did you experience, or are you currently experiencing any of the following:

Symptom	***Yes***	***No***	***Length of Symptoms***	***Explanation***
Fever				
Body Chills				
Extreme Level of Fatigue Cough				
Pain / Difficulty Breathing				
Shortness of Breath				
Sore Throat				
Body / Muscle Aches				
Loss of Taste				
Loss of Smell				
Changes to Vision / Eye Discharge				

Questions:	***Yes***	***No***
2-14 days prior to experiencing these symptoms, did you experience a suspected exposure to COVID-19		
Have you had any direct contact with anyone who lives in or has visited a place where COVID-19 is spreading and / or is an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?		
Have you had a direct contact with someone that has a suspected or lab confirmed case of COVID-19?		
During your time away from school, did you self-quarantine due to suspected symptoms or exposure of COVID-19?		
During your time away from ULL, have you been living in, or have visited an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?		

Have you previously been or are you currently diagnosed with COVID-19? _____ Yes, _____ No – Date of Diagnosis: ____ / ____ / ____

Do you have medical documentation to support your diagnosis and treatment of COVID-19? _____ Yes, _____ No

Physician's Name: _____ Physician Location: _____

Please list any countries / States / Cities you have traveled to since March 15, 2020 and the dates you were there:

1. _____ ***Dates:*** _____
2. _____ ***Dates:*** _____
3. _____ ***Dates:*** _____
4. _____ ***Dates:*** _____

Parent or Legal Guardian please read the following:

- I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing.
- However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of attending practices or workouts.
- I hereby acknowledge and assume the risk of becoming infected with COVID-19 by attending and I give my express permission for above named athlete to attend.

I do hereby certify that all the above is true to the best of my knowledge and consent to the above:

Student-Athlete's Signature: _____ **Date:** _____

Parent/Guardian's Signature: _____ **Date:** _____

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: _____

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 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 of Medical Examination**

This physical expires 13 months from the date it was signed and dated by the MD, DO, APRN or PA.

Revised 6/18

Louisiana High School Athletic Association

Athletic Participation/Parental Permission Form

*This form must be completed and signed **by the student-athlete's parent** prior to a student's participation in an athletic contest and shall be kept on file with the school.* **It shall remain in effect for the remainder of the student's eligibility unless the student transfers to another member school.** *This form is subject to **review**/inspection by the LHSAA **or its representative.***

PART I: STUDENT INFORMATION *(Please Print)*

Student's Name: (Last, First, Middle)_____School Year: _____

Date of Birth:_____Last Four Digits of SSN: _____

Home Address: _____

City:_____Zip: _____

My child entered ninth grade in_____(month and year). Last semester/year he/she attended _____ _____High School.

ARE YOU ELIGIBLE?

A student athlete in an LHSAA school must meet the following rules to be eligible for interscholastic athletic competition:

RULE	COMMENTS
BONA FIDE STUDENT	A student shall be enrolled in and attending an LHSAA member school on a regular basis and taking the required number of subjects which shall be recorded on the student's official transcript unless student is a special education student or in the 8th grade or below. A student shall must be counted as a student on the daily attendance records of the school he/she attends. Attendance in one class makes you a student at that school.
ENROLLMENT	A student shall be enrolled and attending a school in the first 11 school days of the school semester at any school or will be ineligible for the first 30 school days.
AGE	A student shall not become 19 years of age prior to August 1 of this year.
PROOF OF AGE	A student shall provide legal proof of age, which meets the provisions of the LHSAA handbook, to the school administrator to be kept on file at school.
CONSECUTIVE SEMESTERS	Once a student shall enter the ninth grade, he/she shall have eight consecutive semesters to play athletics. (EXCEPTION: Hold-Back Repeat Student – See Rule 1.20.6 of the LHSAA handbook)
SCHOLASTIC	For regular education high school students at the end of the first semester a student shall **pass at least six subjects** in all subjects taken. At the end of the year and prior to the next school year, a student shall must have **earned at least six units with an overall "C" average for the entire previous school year** as determined by the LEA in all units taken. All seniors must take at least four (4) subjects each semester. Special education students must consult the school principal, athletic director, or coach for scholastic information.
RESIDENCE AND SCHOOL TRANSFERS	Upon entering high school for the first time, a student shall have the choice to attend any member school located in the attendance zone in which the student resides with his/her parent(s)/guardian(s) or any other household with whom the student has been residing for the past calendar year and be immediately eligible unless an applicable exception applies. A transfer to another member school in the same attendance zone shall render the student ineligible for one calendar year.
UNDUE INFLUENCE	If a student shall has been recruited to a school for athletic purposes, he/she shall remain ineligible as long as the student attends that school.
AMATEUR	A student cannot play high school athletics if he/she loses their amateur status.
INDEPENDENT TEAM	In certain sports a student cannot play on a school team and an independent team during the same sport season.

MEDICAL EXAMINATION A student shall **annually** pass a physical examination given by a licensed physician/ nurse practitioner that is in collaboration with a licensed physician or a licensed physician's assistant under the supervision of a licensed physician and complete an LHSAA Medical History Evaluation form prior to participating.

ATHLETIC PARTICIPATION/ PARENTAL PERMISSION FORM A school shall **only** be required to have this form completed and signed prior to **the first time a student participates** in LHSAA athletics at the school **unless the student transfers to another member school**.

SUBSTANCE ABUSE/MISUSE CONTRACT & CONSENT FORM A school shall only be required to have this form completed and signed prior to the first time a student participates in LHSAA athletics at the school.

SUSPENDED AND INELIGIBLE STUDENTS Shall not participate in any interscholastic contest on any team at any school at any level.

LHSAA ELIGIBILITY RULES APPLY TO STUDENT-ATHLETES ON ALL TEAMS AT ALL LEVELS OF PLAY AT ALL LHSAA SCHOOLS

Eligibility to participate in interscholastic athletics is a privilege a student earns by meeting standards outlined on this form and other regulations and policies set by the LHSAA and the student's school. If you have questions or do not fully understand an eligibility rule, check with your child's principal, athletic director or coach. By following the intent and spirit of the rules, you can help prevent violations which may penalize the student, his/her team and/or his/her school.

ONE INELIGIBLE STUDENT MAY DISQUALIFY YOUR WHOLE TEAM – KNOW THE ELIGIBLITY RULES

PART II – PARENTAL PERMISSION

I have read and reviewed the general requirements for high school athletic eligibility on this form and have discussed these requirements with my child. I understand additional questions/explanations and specific circumstances should be directed to my child's principal, athletic director or coach.

I certify the home address listed **on this form** is my sole bona fide residence and **that I** will notify the school principal immediately of any change in **my** residence, since such a move may alter the eligibility status of my child. All other information given is also accurate and current.

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. Additionally, I give the LHSAA or it representative(s) permission to review my child's scholastic records and all required eligibility forms **however submitted by the school or myself**.

If the medical status of my child changes in any significant manner after he/she passes his/her physical examination, I will notify his/her principal of the change immediately.

I hereby give my consent and approval for **my child** to participate in ***any*** of the following LHSAA sports:

BASEBALL	GOLF	SWIMMING
BASKETBALL	GYMNASTICS	TENNIS
BOWLING	POWERLIFTING	TRACK AND FIELD
CROSS COUNTRY	SOCCER	VOLLEYBALL
FOOTBALL	SOFTBALL	WRESTLING

I certify all the information is correct, that I have read the summary of LHSAA eligibility rules below and I am in compliance with these standards. I also acknowledge that my child, by my signature below, has my permission to participate in interscholastic athletics during his attendance at this school. I also understand that this form shall only be completed prior to my child's first participation in any athletic contest of any sport and shall remain in effect for his/her entire athletic eligibility unless he/she transfers to another member school.

By signing below, I agree that my child and I will support and comply with all rules, policies and procedures of the LHSAA as set forth in its Handbook, including its Constitution and Bylaws.

Date:_____ **Parent's Signature:** _____

Relationship to Student _____ **(Print Name)** _____

(Principal Signature) Shelly C. Gaydos

LHSAA SUBSTANCE ABUSE/MISUSE CONTRACT AND CONSENT FORM

This form must be completed and signed and kept on file with the school and is subject to inspection by the LHSAA Rules Compliance Team.

As an LHSAA athlete, I, _____, agree to avoid the abuse or misuse of legal or illegal substances, including anabolic steroids and other performance enhancing drugs. I hereby grant permission to be tested for substance abuse/misuse as a participant in any LHSAA sports program. I furthermore agree to cooperate by providing a urine or hair specimen for testing upon the request of my principal. I understand that should my specimen indicate the abuse or misuse of legal or illegal substances, I will be subject to action specified in my School Drug Policy for Student Athletes.

I, _____, parent/guardian of the undersigned student athlete, individually, and on behalf of my child, do hereby grant permission for and consent to said child being tested for substance abuse/misuse in accordance with his/her School Drug Policy for Student Athletes and I understand that if any specimen taken from him/her indicates abuse or misuse of legal or illegal substances, including anabolic steroids and other performance enhancing drugs, he/she will be subject to action specified in the School Drug Policy for Student Athletes for his/her school.

Dated: _____ _____
Student Athlete

Dated: _____ _____
Parent/Guardian

Dated: 5/10/2021 Shelly C. Gaydos

Dated: 5/10/2021 Amber A. Babin
Head Coach or AD

1.9 ABUSE AND/OR MISUSE OF ILLEGAL SUBSTANCES - Each member school shall develop and implement a substance abuse/misuse policy including procedures for chemical testing of student-athletes. To be eligible for interscholastic athletics, prior to practicing or participating in a sport at an LHSAA school, a student-athlete and his/her parent(s)/guardian shall sign the LHSAA Substance Abuse/Misuse Contract developed and distributed to all schools by the LHSAA. Once signed, the LHSAA Substance Abuse/Misuse Contract shall remain in effect for the remainder of the student-athlete's eligibility. Schools may also have the student and parent/guardian sign a school issued form in addition to the LHSAA Substance Abuse/Misuse Contract. Schools shall be required to keep the signed form on file at the school.

1.9.1 The penalties for failure to have the required LHSAA Substance Abuse/Misuse Contract(s) for all students completed, properly signed, and maintained in the school files shall be:
1. A school shall be fined $50 per student, per sport for each LHSAA Substance Abuse/Misuse Form not completed, properly signed, and on file with the school not to exceed $500 per sport.
2. A student in violation of this rule shall not be ruled ineligible for this infraction, but shall be withheld from further team practices and interscholastic athletic participation until a copy of this form is completed and submitted to the Executive Director. The completed form must be faxed or postmarked prior to the athlete's participation

Signature of the LHSAA's contract does not necessarily mean the student athlete will be tested.

NORTH OAKS
HEALTH SYSTEM

P. O. Box 2668 HAMMOND, LA 70404
(985) 345-2700

AUTHORIZATION TO DISCLOSE DRUG SCREEN RESULTS

I hereby authorize **NORTH OAKS HEALTH SYSTEM** to disclose the drug screen results of:

Student Name: _____ **DOB:**_____

Release to:

Client Name: Tangipahoa Parish School System **School**:_____

Sport:_____

The information will be disclosed for the following purpose:

Student athlete random drug screen required for participation in school athletics.

FOR RELEASE OF INFORMATION TO SOMEONE OTHER THAN TO THE PATIENT:

Health information released as a result of this authorization may be re-disclosed or shared by the person or entity receiving the information and may not be protected by federal/state regulations.

I understand that I may refuse to sign this authorization. I further understand that my refusal to sign will not affect my ability to obtain treatment unless a third party requests the service and/or release of information. (For example, if you present for a drug test solely for the purpose of having the results disclosed to your employer, North Oaks may refuse to perform the drug test if you refuse to sign this form.)

I understand that I may revoke this authorization in writing at any time. Revocation will be effective when received by North Oaks Health System. I further understand that any information already authorized and released is not covered by this revocation.

Drug screen results are utilized for athletic eligibility purposes. This authorization expires **upon completion of athletic eligibility.**

_____ _____

Signature of Parent/Legal Guardian **Date**

_____

Print Name of Parent/Legal Guardian

_____

Donor/Student's Signature

Not of Legal Age

Reason Donor/Student Cannot Sign

(A copy of this signed form will be provided to the donor/student as the drug screen collection is performed)

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

NORTHOAKS
Health System

P.O. Box 2668 • HAMMOND, LA 70404 • (985) 345-2700

AUTHORIZATION

I hereby authorize North Oaks Health System to photograph my image, interview and/or record my testimony for the purpose of promotion of North Oaks Health System and/or its wholly-owned subsidiaries and other affiliated entities (hereinafter "NOHS"). Examples of promotion include, but are not limited to, brochures, newsletters, TV and radio commercials, newspaper ads, NOHS web-sites (i.e., www.northoaks.org), and social media networks (i.e., YouTube, Facebook, Twitter). I understand that I may refuse to sign this authorization. I further understand that my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization in writing at any time sent to the attention of NOHS Corporate Communications, P.O. Box 2668, Hammond, LA 70404. I understand that I will not be financially compensated for the use of my image.

Revocation will be effective when received by NOHS. I further understand that any information already authorized and released/used is not covered by this revocation. NOHS will not receive monetary benefit from the use/disclosure of this information.

This authorization expires five (5) years from the date of signature below.

Print Name: _____
(Subject of photograph or interview)

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (_____) _____ – _____

Subject's School Name: _____

Subject's Sport(s): _____

Subject's Jersey Number(s): _____

_____ _____/_____/_____
Signature of Interviewee (Parent/Guardian, if Minor) Date

(A copy of this signed authorization must be provided to the individual.)

FOR OFFICE USE ONLY.

Related Project: _____

NORTH OAKS
Sports Medicine

ImPACT®

Dear Parent/Guardian,

North Oaks Sports Medicine is using Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT®), an advanced program to help our team physicians and athletic trainers evaluate and treat traumatic brain injuries (e.g., concussion) in our student-athletes. ImPACT® is a computerized exam used by many professional, college and high school sports programs across the country. If an athlete is believed to have suffered a head injury during practice or competition, ImPACT® is a tool that can be used by a trained health care professional to evaluate the seriousness of the head injury and the athlete's recovery from that injury. Your permission is required before we can test your student-athlete.

Ideally, the computerized exam is given to athletes before beginning contact sport practice or competition. This simple test is set up in a video-game type format and takes about 20 minutes to complete. It tracks information such as memory, reaction time, speed and concentration. In addition, to help health care providers better understand the athlete's particular health care situation, there are also questions about the athlete's health history as well as current symptoms that he or she may be experiencing. ImPACT® is not an IQ test and is non-invasive (no surgical cuts or breaks to the skin are required).

If a concussion is suspected, the athlete will be required to retake the test. The athlete's performance on the post-injury test will be compared to his or her performance on the baseline and any differences in performance will be evaluated by a trained health care provider. The test data will help trained health care professionals determine when return-to-activity is appropriate and safe for the injured child.

I wish to stress that the ImPACT® testing procedures pose no known risks to your student-athlete. We are excited to implement this program because it provides us the best available information for managing concussions. Please return the attached page with the appropriate signatures by _____. If you have further questions regarding this program please feel free to email me at kulbethj@northoaks.org or call me at (985) 230-5248.

Sincerely,

Jeremy Kulbeth

Jeremy Kulbeth
Lead High School Athletic Trainer
North Oaks Sports Medicine

Physical: Southeastern Louisiana University Campus • Dugas Center, 2nd Floor • 800 Galloway Drive • Hammond, LA 70402 • (985) 230-5248
Mail: P.O. Box 2668 • Hammond, LA 70404 • (985) 345-2700 • www.northoaks.org

NorthOaks Sports Medicine

ImPACT®

CONSENT FOR BASELINE COGNITIVE TESTING AND RELEASE OF INFORMATION

NOTE OF CONSENT

I give my permission for *(Student-Athlete's Full Name)* _____,
to have a baseline Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT®) test administered at *(Facility Location)* _____. I understand that my child may need to be tested more than once, depending upon the results of the test. I understand there is no charge for the testing.

Student-Athlete's Date of Birth: _____/_____/_____
Student-Athlete's Mailing Address: _____
_____
Full Name of Parent/Guardian *(Please print)*: _____
Parent/Guardian Phone Number: (_____) _____ Preferred Time to Call: _____ *(a.m. or p.m.)*

Signature of Parent/Guardian: _____ Today's Date: _____/_____/_____

RELEASE OF INFORMATION

North Oaks Sports Medicine may release the ImPACT® test results to my child's primary care physician, neurologist, other treating physician or any licensed health care professional listed below:

Physician/Licensed Health Care Professional *(First and Last Name)*: _____
Clinic or Practice Name: _____
Phone Number: (_____) _____

Physician/Licensed Health Care Professional *(First and Last Name)*: _____
Clinic or Practice Name: _____
Phone Number: (_____) _____

Physician/Licensed Health Care Professional *(First and Last Name)*: _____
Clinic or Practice Name: _____
Phone Number: (_____) _____

I understand that general information about the test data may be provided to my child's guidance counselor and teachers for the purposes of providing temporary academic modifications, if necessary.

Signature of Parent/Guardian: _____ Today's Date: _____/_____/_____