STATE OF LOUISIANA

SCHOOL ENTRANCE & GENERAL HEALTH EXAM FORM/ LHSAA MEDICAL HISTORY EVALUATION

See instructions on page 4. LHSAA student athletes using this form for their 2nd, 3rd or 4th years of eligibility are only required to show changes on this form.

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. State law (R.S. 17:170) requires that all persons entering any school for the first time be up to date in their immunizations. Important: This form must be kept on file with the school and is subject to inspection by the LHSAA Rules Compliance Team. It is important to keep all contact information current at all times.

Name of School:			Grade:	
Student's Name: Last	First		M.I.	
Student's Date of Birth:	Sex: ❑ M ❑ F		State or Country of Birth:	
Student's Mailing Address:	City:		State:	Zip Code:
Student's Physical Address:	City:		State:	Zip Code:
Name of Mother or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:

Please check the type of health insurance your child has: ❑ Private ❑ Medicaid/LaCHIP ❑ None

If your child does not have health insurance, would you like information on no cost health insurance? ❑ Yes ❑ No

In case of emergency—if parent or legal guardian cannot be contacted—contact the following:
Name Complete Phone Number ( )

PART 2: PARENT OR LEGAL GUARDIAN TO COMPLETE. Below is an assessment of your child's health. To the best of your knowledge, has your child had any problems with the following? Please check yes or no.

General Health Questions	Yes	No	Comments if "Yes" and date of last occurrence
Had/have a medical problem or injury since last evaluation?			
Ever not been allowed to participate in sports for a medical reason?			
Have any missing organs? (eye, kidney, testicle, etc.)			
Been dizzy or passed out during or after exercise?			
Had/have chest pain during or after exercise?			
Tire more quickly than his/her friends during exercise?			
Have a family member that died of heart problems before age 50?			
Had/have a family member with sudden death before age 50?			
Ever been knocked out or unconscious?			
Ever had a stinger, burner or pinched nerve?			
Ever had heat cramps?			
Ever been dizzy or passed out in the heat?			
Have trouble with breathing or coughing during or after activity?			
Ever sprained/strained, dislocated, fractured bones or joints?			
Ever had repeated swelling of any bones or joints?			
Use any special equipment? (pads, braces, neck rolls, eye guards, kidney belt, etc.)			
Condition	**Yes**	**No**	**Comments if "Yes" and date of last occurrence**
Anemia			
Allergies (food, insects, medications, latex)			
Allergies (seasonal)			
Asthma or breathing problems			
Attention-Deficit/Hyperactivity Disorder			
Behavioral problems			
Chicken Pox			
Developmental problems			
Bladder problem			
Bleeding problems			

Name: _____ DOB: _____

Condition	Yes	No	Comments if "Yes" and date of last occurrence
Bowel problem			
Cerebral Palsy			
Cystic Fibrosis			
Dental problems			
Diabetes			
Head or spinal Injury			
Hearing problems or deafness			
Heart problems			
Racing of the heart or skipped heartbeats			
Hepatitis			
High blood pressure			
Hospitalizations (when, why)			
Lead poisoning			
Mononucleosis			
Muscular problems			
Rheumatic Fever			
Seizures			
Sickle Cell Disease (not trait)			
Skin problems			
Speech problems			
Surgery			
Tuberculosis			
Vision problems			
Other:			

List all prescription and over-the-counter medications your child takes regularly:

Describe any other important health-related information about your child (i.e., feeding tube, oxygen support, hearing aid, etc.):

Name of your child's pediatrician or primary care provider:	Names of medical specialists or special clinics caring for your child:

Has your child ever seen a dentist? ❑ Yes ❑ No	If yes, date of last appointment:

Name of your child's dentist:

For Parents/Legal Guardians of Students

The information on this form is current and correct to the best of my knowledge. 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 school nurse of the change immediately. In an emergency medical situation, I give permission for the school nurse or other school authority to share protected health information related to the emergency with the emergency contact.

For Parents/Legal Guardians of the Student Athlete Only

I give my permission for my child to be examined for school-related activities and for this information and the completed physical examination report to be shared with school personnel and those affiliated with the team on a need to know basis. 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 and exchange of information as may be deemed necessary. I recognize the evaluation to be done on my child is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work, or cardiac testing will be performed unless deemed necessary by the health care examiner. 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. I give my permission for the athletic trainer, head coach, athletic director/principal of his/her school to release information concerning my child's medical examination, injuries or medical conditions to any medical provider who treats my child for a school-related or athletic injury or who is treating my child at my selection for any condition.

By signing below, I am agreeing to the above.

Signature of Parent or Legal Guardian:	**Date:**
Signature of Interpreter (if applicable):	**Date:**

KEY: WNL = Within Normal Limits
UTD = Up to Date
UTO = Unable to Obtain
IP= In Progress

STATE OF LOUISIANA
COMPREHENSIVE PHYSICAL EXAMINATION REPORT

PART 3: To be completed by a licensed physician/licensed nurse practitioner in collaboration with a licensed physician or a licensed physician's assistant under the supervision of a licensed physician.

Name: _____ Ht. _____ Wt. _____ BMI _____ Age _____
DOB: _____ BP _____ T _____ P _____ R _____
Current Meds: Allergies:

Past Medical History
Major illness _____
Hospitalizations/Surgeries _____
Immunizations (incl. Varicella): □ UTD □ IP
Note: Attach proof if school entrance form.

Family History
Allergy or Asthma_____

Family History (cont.)
Diabetes_____
Cancer_____
Heart Disease_____
Sickle Cell_____
T.B._____
Other:_____
(Note family member's relation to patient.)

Environmental Assessment
Water supply: City Well None
Sewer system: City Septic None
Smokers in the home? _____
Pets in home: List:_____

Nutritional Assessment
□ Special Diet _____
□ Vitamins/Supplements _____
□ Growth Chart WNL (See Grid)
Comments: _____

Dental Assessment

Any Dental Disease	□Yes	□No
Dental Caries	□Yes	□ No
Brush Teeth Regularly	□Yes	□No
Dental Visit in the last year	□Yes	□No

Reproductive
Menarche age_____ LMP_____

Vision Screen (if indicated) □ Not indicated

Subjective: any eye disorder	□ Yes	□ No
F.H. of eye disorder	□ Yes	□ No
Wear glasses/contacts	□ Yes	□ No
Objective: visual acuity	R 20/__	L 20/__
with glasses/contacts	□Yes	□No
Muscle balance	□ pass	□ fail
Color perception	□ pass	□ fail

Hearing Screen (if indicated) □ Not indicated
Subjective: response to voices □ Yes □ No
Delayed speech development □ Yes □ No
Recurrent O.M. □ Yes □ No
Hearing 20 db HL (pass or fail)

	1000Hz	2000Hz	4000Hz
Right ear	_____	_____	_____
Left ear	_____	_____	_____

Labs (if indicated) □ Not indicated
Hct or Hgb: □WNL □UTD □UTO
Values: _____
Urine Dipstk: □WNL □UTD □UTO
Comments: _____
Lead if indicated (see criteria) ____

Review of System	WNL	Abnl.	Comments	Objective: PE	WNL	Abnl.	Comments
Constitutional				General Appearance			
Eyes				Skin			
ENT				Head			
CV				Eyes			
Respiratory				ENT			
GU				Mouth/Teeth			
GI				Neck			
Musculoskeletal				Chest			
Integumentary				Heart			
Neuro.				Lungs			
Psychiatric				Abdomen			
Endocrine				Genitalia (Tanner Stage)			
Hemat./Lymphatic				Neurological			
Allergic/Immuno.				Musculoskeletal			

Social History/Devel. Assessment (Use additional sheets for more info.)

Cognitive Devel.	
Speech/Lang. Devel.	
Social/Emot. Devel.	
Health Beh./Habits (Drugs/ETOH/Tobacco)	

Anticipatory Guidance
Nutritional/Diet _____
SkinCare/Hygiene _____
Oral/Dental _____
Behavioral/Devel. _____
Safety _____
School Status _____
Health/Reproduction _____
High Risk Activities _____

Assessment: _____
Plan: _____
Follow-up/Resolution:

For Student Athlete Only: Student Sports/Physical Activity Clearance
□ A. Cleared □ B. Cleared after further evaluation/treatment □ C. Not cleared for: □Collision □Contact □Non-contact

Medical Provider's Name (print):_____ Phone #: _(_____)_____

Signature of Medical Provider: **Date:**

Instructions and Definitions/Criteria

This form is to be used for the Louisiana High School Athletic Association (LHSAA) medical history evaluation. It may also be used as a school entrance and/or general health exam at the local school district's discretion. If this form is being used for school entrance, proper immunization documentation is also required. (See below).

Instructions for the Parent/Legal Guardian:

Complete pages 1-2 as instructed. Sign the bottom of page 2. A licensed medical provider must complete Page 3.

Instructions for the Medical Provider:

Review pages 1-2 and complete page 3 as instructed. Sign the bottom of page 3. Attach proper immunization documentation if this form is being used for school entrance.

Immunization Documentation:

Louisiana State law (R.S. 17:170) requires proper immunization documentation on all students upon entry to school. *Louisiana Immunization Network for Kids Statewide* (LINKS) is a statewide, web-based immunization tracking system, which replaced over 30 years of "pink cards," collected statewide in public health. It is preferable to submit the LINKS print out now available in many physician offices. Other acceptable forms include the IMM-1 card that can be obtained from the Louisiana Office of Public Health (OPH)/Immunization Program or other proof of immunization that includes dates of series with an authorized signature.

Physicians may contact the OPH/Immunization Program at 504-483-1900 to obtain more information on LINKS or to obtain blank IMM-1 cards. Please note that there will be a time when only the LINKS print out will be accepted for school entry.

Definitions/Criteria for the Medical Provider:

Anemia Screen (if indicated)

Perform screen if indicated based on history or clinical findings. Louisiana KIDMED (EPSDT) requires periodic hemoglobin or hematocrit measurement of Medicaid recipients according to the Louisiana KIDMED Periodicity Schedule that can be found at: www.la-kidmed.com/kidmed/docs/periodicity.pdf. The American Academy of Pediatrics recommendation for anemia screening can be found at: http://aappolicy.aappublications.org/policy_statement/index.dtl#R. Click on Policy Statement: Recommendations on Practice and Ambulatory Medicine (03/01/00).

Urine Screen (if indicated)

Perform screen if indicated based on history or clinical findings. Louisiana KIDMED (EPSDT) requires periodic urine dipstick of Medicaid recipients according to the Louisiana KIDMED Periodicity Schedule.

Vision Screening (if indicated)

Perform screen if indicated. Louisiana State law (R.S. 17:2112) requires that the school system test the visual acuity and muscle balance of all students according to the schedule established by the American Academy of Pediatrics. The law also requires the school system to test every first grader for color perception. Louisiana KIDMED (EPSDT) requires subjective and objective vision screening of Medicaid recipients according to the Louisiana KIDMED Periodicity Schedule.

Hearing Screen (if indicated)

Perform screen if indicated. Louisiana State law (R.S. 17:2112) requires that the school system test the hearing of all students according to the schedule established by the American Academy of Pediatrics using pure tone audiometer. Louisiana KIDMED (EPSDT) requires subjective and objective hearing screening of Medicaid recipients according to the Louisiana KIDMED Periodicity Schedule.

Blood Lead Test (if indicated)

Perform screen if indicated. It is recommended by the Centers for Disease Control and Prevention/Childhood Lead Poisoning Prevention Program that a risk assessment questionnaire is administered at every well baby visit (6-72 months) and that all children receive a blood lead test at ages 1 and 2, or, if between 3 and 6 years of age and not previously tested. Louisiana KIDMED (EPSDT) requires all Medicaid recipients receive a blood lead test at ages 1 and 2, or, if between the ages of 1 and 6 years of age and not previously tested.