

BRSC 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: _____ Team: _____ Date: _____
 Cell Phone: _____ Home Phone: _____ Work Phone: _____ Sex: M / F Date of Birth: _____
 Home Address: _____ City: _____ State: _____ Zip Code: _____ Age: _____
 Parent / Guardian: _____ Employer: _____

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
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Sudden Death	_____	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait/Anemia	_____	<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	Yes	No	Condition	Date
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury / Concussion	_____	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury / Stinger	_____	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder L / R	_____
<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"/>	Back	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hip L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Thigh L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Knee 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"/>	Ankle L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Foot L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Severe Muscle Strain	_____	<input type="checkbox"/>	<input type="checkbox"/>	Pinched Nerve	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chest	_____	<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgeries:	_____				

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: _____

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 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,

- If, in the judgment of a Baton Rouge Soccer Club staff member, the named 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**
- 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 BRSC coach and medical staff of the change immediately..... **Yes No**
- I give my permission for the BRSC medical staff to release information concerning my child's injuries to his/her BRSC coach and BRSC administrative staff **Yes No**
- 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 BRSC staff **Yes No**

Date Signed by Parent _____ Signature of Parent _____ Typed or Printed Name of Parent _____
COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPTHIC DR. (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

Height _____	Weight _____	Blood Pressure _____	Pulse _____
--------------	--------------	----------------------	-------------

GENERAL MEDICAL EXAM:

	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"/>

COMMENTS: _____

ADDITIONAL EXAM:

VISION:
 L: _____ R: _____ Corrected: _____

ORTHOPAEDIC EXAM:

	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 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"/>

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 one year on the last day of the month that it was signed and dated by the MD, DO, APRN or PA.