# Lafourche Parish School Board

## Athletic Participation Packet
## 2020 – 2021

The following forms should be issued to and completed by all Lafourche Parish Student-Athletes:

| Form | Middle School | High School |
|---|---|---|
| LHSAA Medical History Evaluation | X | X |
| Parent or Guardian Consent, Indemnity, and Insurance Election | X | X |
| Emergency Information | X | X |
| Risk Acknowledgement | X | X |
| Drug Screening Consent | X | X |
| Concussion Statement | X | X |
| The Risk of Concussion and Head Injury | X | X |
| Quitting a Sport | X | X |
| LPSB Student Accident Coverage | X | X |
| Sports Participation Agreement Summary | X | X |
| LHSAA Substance Abuse Agreement | | X |
| LHSAA Athletic Participation/Parental Permission | | X |

# LHSAA MEDICAL HISTORY EVALUATION

*Middle & High School*

**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.**

HB: 21

*Revised 6/18*

Lafourche Parish School Board *Middle & High School*

Parent or Guardian Consent, Indemnity, and Insurance

Form **From July 1, 2020 – August 1, 2021**

Student's Name _____

School _____

Activity _____

Consent and Indemnity

The undersigned parent(s) or legal guardian(s), as the case may be, of the student named above hereby consent to his or her participation in the activity conducted by the public schools of Lafourche Parish, and recognize and acknowledge that the injuries may occur to the student as a result of participation in those activities. To the extent permitted by law, consenting to the student's participation in such activities, the undersigned parent(s) or legal guardian(s) hereby agree to hold harmless the Lafourche Parish School Board, its members, employees, agents, assigns and insures from and against all liability for any accidents involving the student while participating in such activities and any injuries suffered by the student during, or as a result of, such participation. The undersigned parent(s) or legal guardian(s) hereby also understood that this authorization is not intended to, and does not: modify the foregoing indemnity provision in any manner whatsoever.

INSURANCE ELECTION

(Please initial the appropriate provision)

_____ As parent or legal representative of the student named above, I acknowledge that insurance against loss caused by injury to my child while participating in the activities described above is available for purchase from School Board Parish Student Insurance.
**I agree to purchase or have purchased** such insurance prior to the student's participation in such activities, and I agree to submit all claims for injuries incurred by the student during such participation to that insurance company. I understand and agree that the Lafourche Parish School Board, its members, employees, agents, assigns, or insurers shall not be responsible for payment of any bills not covered by such insurance.
***Please provide a copy of purchase confirmation.**

_____ As parent or legal representative of the student named above, I acknowledge that insurance against loss caused by injury to that student while participating in the activities described above is available for purchase from Lafourche Parish Student Insurance.
**I do not wish to purchase that insurance.** I understand and agree that I will be fully and personally responsible for payments of any and all bills incurred by us as a result of any injury suffered by the student while participating in such activities. I further understand and agree that the Lafourche Parish School Board, its members, employees, agents and/or assigns shall not be responsible for payment of any such bills.

**No student will be permitted to begin participation in organized school activities until this form has been completed and signed by the parent(s) or legal representative(s) of the student.

Parent or Legal Representative/Date: _____

**Athletic Department**
**Emergency Information and Parent Consent**

***General Information:***

Athlete's Name: _____ Date of Birth: _____
Mailing Address: _____ City: _____
Parent's Name: _____ Home Phone No: _____
Parent's Employer _____ Work Phone No: _____
Insurance Company _____ Policy # _____
In an emergency, if the parents cannot be reached, notify:
Name: _____ Phone No: _____
Name: _____ Phone No: _____

***Health Information:***

Family Doctor: _____ Phone No: _____
Family Dentist: _____ Phone No: _____
Known Allergies: _____
Current Medications: _____
Answer YES or NO to the following: (If yes, please explain on back of sheet)

*Asthma:* _____ *Inhaler:* _____ *Concussion:* _____

*Diabetic:* _____ *Skin Condition:* _____ *Seizure:* _____

***Consent Forms:***

In an emergency, I give permission for the coach, athletic trainer and/or team physician to use their judgement in securing medical care and/or an ambulance.

Also, permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above-named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

**Parent/Guardian Signature** _____ **Date** _____

I give permission for the school athletic trainer (coach) to speak with physician(s) regarding my child's health status as it pertains to athletic participation.

**Parent/Guardian Signature** _____ **Date** _____

I give permission for coaches, athletic director, principal, and guidance counselors to give copies of my child's transcript to college coaches and/or college recruiters.

**Parent/Guardian Signature** _____ **Date** _____

- **Risk Acknowledgement**

# Lafourche Parish Athletics

I am aware that trying out, practicing, playing, or any form of participation in any sport can be a dangerous activity involving **MANY RISKS OF INJURY.**

I understand that there are risks of injuries in any sport, but are not limited to death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system and serious injury or impairment to other aspects of the body, health, and well-being.

I also understand that the dangers and risks of engaging in any sport may result not only in serious injury, but in a serious impairment of future abilities of my child/ward to earn a living and to engage in business, social, and recreational activities and generally to enjoy life.

Because of the risks described above, I recognize the importance of my child/ward listening to and following all of the coach's instructions and warnings regarding playing techniques, training methods, rules of the sport and other team rules. I also recognize the importance of my child/ward reading and adhering to all written instructions, written warnings regarding playing techniques, training methods, rules of the sport and other team rules. I therefore expressly agree to direct and to encourage my child/ward to obey all of the coach's instructions.

In consideration of the Lafourche Parish School Board permitting my child/ward to try-out, practice, play or in any other way, participate for an athletic team and to engage in all the activities related to the team, including practice, conditioning, playing, and traveling. **I hereby acknowledge that my child/ward assumes all the risks associated with such participation. My child/ward and I agree to waive all claims of whatever nature**, fully and finally, now and forever, for my child/ward, for myself, my estate, my heirs, my administrators, my executors, my assignees, and for all members of my family, and to release, exonerate, discharge and hold harmless the above named school board, school, their trustees, officers, agents, servants, employees, successors, and assigns, their athletic staff, all coaches, assistant coaches, athletic trainers, physicians, and other practitioners of the healing arts from any liability, claims, causes of action or demands arising out of any injuries to my child/ward or to his/her property or losses of any kind which may result in or connection with his/her participation in any activities related to the Lafourche Parish sports program.

**I understand that the Cautionary Statements for each sport is found in the athletic participation handbook.**

Baseball/ Softball/ Basketball/ Cross Country/ Football/ Golf/ Soccer/ Swimming/ Tennis/
Track & Field/ Volleyball/ Weight Lifting/ Power Lifting

_____ _____

Parent/Guardian's Signature Student-athlete's Signature

_____

Date

# Drug Screening Policy and Consent

**Effective August 2013, Policy IDFAA – Drug Screening of Student Athletes, will be implemented. This complete policy can be found on the Lafourche Parish School Board website in the Policy Manual under the "about us" tab. The following is an excerpt from Policy IDFAA:**

*Based on the process outlined below and based upon the availability of funding, all student-athletes of each sport may be required to submit to a drug screening on a date set by the Athletic Director, Principal, Head Coach, and Drug Screening Company prior to the first contest of that season. In addition to the initial screening of all student-athletes, additional random testing shall be administered throughout the season. The frequency of the additional random tests will be determined by the School Principal, Athletic Director and Head coach of that sport based on the following guidelines and procedures: As frequent as once each week of the season, but no less than once each month of the season, the names of the athletes shall be placed in a "pool" from which a representative of the contracted laboratory, with the supervision of two representatives of the Lafourche Parish School Board, draws the names of up to 15% but not less than 5% of the athletes for random testing.*

I, _____, knowingly and willingly authorize the Lafourche
***Student's Name***
Parish School District to conduct a specific test on a urine specimen which I provide to ascertain whether or not there is evidence of my use of drugs and/or alcohol. I also agree to release information concerning the results of such a test to the Lafourche Parish School District, through its agents (the Superintendent and/or Designee) and to my parents and/or guardian (tutor/tutrix).

If I am, or have been, taking prescription medication, I agree that I shall provide verification of the prescription medication (either by a copy of the prescription or doctor's authorization) upon request. My refusal could be a factor in determining my privilege to participate in school athletics.

I am aware and agree that this requested information concerning prescription medication shall be provided to the system's appointed medical review officer for review.

I am further aware and agree that the consent form shall be binding for as long as I avail myself of the privilege of participating in athletics in the Lafourche Parish School System.

I further understand and agree that the Lafourche Parish School System is not assuming any medical obligations but is merely acting to help achieve a safe athletic environment.

| _____ | _____ | _____ |
|---|---|---|
| **Student Signature** | **Date** | **Student ID No.** |
| _____ | _____ | |
| **Parent or Guardian Signature** | **Date** | |
| _____ | _____ | |
| **School Representative Signature/Title** | **Date** | |
| _____ | | |
| **School** | | |

# Concussion: Statement of Student-Athlete Responsibility and Parent Awareness
# Louisiana Youth Concussion Act 314

**What is a Concussion?**

A concussion is a brain injury caused by a blow to the head, face or elsewhere on the body with a force transmitted to the brain. Concussions can result from hitting a hard surface such as the ground floor, from players colliding with each other or from being hit by a ball, bat or other sporting equipment.

**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.

**Signs and Symptoms of Concussion can Include:**

Headache or "pressure" in head
Balance or blurry vision
Sensitivity to light or noise
Confusion
Sensation that one does not "feel right"
Nausea or vomiting
Double vision
Feeling sluggish, hazy, foggy or groggy

**For more information:**

***cdc.gov/concussion***

**Why knowing you have a Concussion is Important**

Most concussions resolve but some concussions can lead to chronic symptoms such as headache, decreased memory, sleeping problems, or personality changes. Rest, avoiding another blow to the head, and following the advice of your medical staff are critical in helping you recover as fast and as safely as possible. Sustaining another concussion prior to recovery from the first increases your chance of long term symptoms. There have been reports of death with a second concussion in younger athletes. It is very important for you to report any concussion symptoms as described above to your athletic trainer, coach or physician at the time of the injury. This includes alerting the medical staff to symptoms in your teammates if you notice these.

**Statement of Student Athletic Responsibility**

I accept responsibility for reporting all injuries and illnesses to the athletic trainer and/or coach. I will report any signs and symptoms of a Concussion. I have read and understand the above information on concussions. I will inform the athletic trainer and/or coach immediately if I experience any of these symptoms or witness a teammate with these symptoms.

_____ _____ _____

**Athlete Name (Print)** **Athlete Signature** **Date**

As the 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 Name (Print)** **Parent Signature** **Date**

**Athlete and Parent Notification: The Nature and Risk of Concussion and Head Injury**

ACT 314 of the 2011 Louisiana legislative session requires all athletes and their parents/legal guardians to receive documented education on concussion and head injury prior to participation in athletic activities. The law applies to all private and public organized youth athletic activities where participants are between the ages of 7 – 19, and includes all elementary, middle, junior, and senior high schools.

**What is a Concussion?**
A concussion is a traumatic brain injury. It can be caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. The traumatic brain injuries can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly**. In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports ***any one*** of the signs or symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, remove your child from activity and seek medical attention right away.

**Symptoms experienced by the athlete may include one or more of the following:**
Headaches, "pressure in head," nausea or vomiting, neck pain, balance problems or dizziness, blurred, double, or fuzzy vision, sensitivity to light or noise, feeling sluggish or slowed down, feeling foggy or groggy, drowsiness, change in sleep patterns, amnesia, "doesn't feel right," fatigue or low energy, sadness, nervousness or anxiety, irritability, more emotional, confusion, concentration or memory problems (forgetting game plays), repeating the same question/comment

**Signs observed by teammates, parents and coaches include one or more of the following:** appears dazed, vacant facial expression, confused about assignment, forgets plays, is unsure of game, score, or opponent, moves clumsily or displays lack of coordination, answers questions slowly, slurred speech, shows behavior or personality changes, can't recall events prior to hit, can't recall events after hit, seizures or convulsions, any change in typical behavior or personality, loses consciousness

**RED FLAGS: Call your doctor or take your child to the emergency department if any of the following signs or symptoms develop after a suspected concussion or head injury:**
headaches that worsen, seizures, neck pain, looking very drowsy and cannot be awakened, repeated vomiting, slurred speech, cannot recognize people or places, increasing confusion, weakness or numbness in arms or legs, unusual behavior changes, increasing irritability, loss of consciousness

**What should happen if an athlete appears to have sustained a concussion?**
1. The child should be removed from activity immediately.
2. Seek medical attention for the child right away.
3. Do not allow the student to return to play until proper medical clearance and return to play guidelines have been followed.

**Physical rest is part of the recovery from a concussion**.
Limit your child's physical activity by not allowing any participation in physical exertion while recovering from a concussion. Adequate rest, including getting plenty of sleep, is important. Daytime rest breaks or naps may be needed. Good nutrition and hydration are also helpful to the healing process.

**Cognitive rest is part of the recovery from a concussion. Activities that require a lot of thinking or concentration can make a concussion worse.** Cognitive rest means the child should refrain from all activities that involve mental exertion, such as working on a computer, watching television, using a cell phone, reading, playing video games, text messaging, and listening to loud music. Any of these activities may exacerbate symptoms and could delay recovery.

**What about classwork after my child has received a concussion?**
A student athlete who has sustained a concussion may look "normal," but by definition the brain may not be working properly. The child, quite simply, is not "faking it." A concussion may result in impaired attention, difficulties with concentrating for prolonged periods of time and memory problems. If prolonged classroom exposure causes a student's condition to worsen (i.e., increased headache, increased fatigue, decreased ability to concentrate, sensitivity to noise or light), then we will work with you and your child's physician to modify their academic environment and expectations until the concussion is resolved. Often students want to quickly take the hardest tests or get the most difficult work "out of the way," but that approach can actually worsen symptoms and prolong recovery. If the child is allowed to attend school, participation in physical education will not be allowed until written clearance and the graduated return to activity is complete.

**What can happen if my child returns to activity too soon (before a concussion is fully healed)?**
There is a condition known as "second impact syndrome" that occurs when a second concussion is received before the first concussion is fully healed. The result of second impact syndrome can be immediate and irreversible catastrophic brain swelling or death. It is also important to know that repeated mild brain injuries occurring over an extended period of time (months or years), even when the brain is fully healed between events, can result in cumulative neurologic and cognitive deficits. Always keep your health care providers informed of your child's concussion history.

**What is required for my child to be allowed to return to sports following a concussion or head injury?**
By law a youth athlete who has been removed from play for concussion must receive written clearance for return to play. We require that this clearance be received from a physician that has that has received training in neuropsychology or concussion evaluation and management. Additionally, high school athletes participating in LHSAA sports should note that there is a specific form the LHSAA requires for concussion clearance.

**Why should my child participate in a gradual return to play plan?**
Activity levels that progress too quickly might cause concussion symptoms to return. After written clearance is received from the physician, the school may require athletes to complete a graduated progression under the supervision of a certified athletic trainer that includes:

Day 1. rest until asymptomatic (physical and mental rest)
Day 2. light aerobic exercise (example: stationary cycle or walking laps for 30 minutes)
Day 3. sport-specific exercises at moderate effort for less than 1 hour (example: moderate jog, moderate footwork drills, shooting drills)
Day 4. non-contact training drills at full effort for less than 1 ½ hours (example: sprinting/running, full speed drills in non-contact situation, light resistance training)
Day 5. full contact training after medical clearance (this must be a practice situation and not competition)
Day 6. return to competition (game play) Note: each "Day" is 24 hours (no accelerated days).

Careful attention to symptoms, thinking, and concentration is needed at each stage of activity. If any concussion signs or symptoms do recur, the activity will be stopped and the athlete returned to level one to restart the progression.

If any of the foregoing is not completely understood and you have questions, please contact the school administrator or athletic director for further information.

**We have read and understand the information above and I give permission to my son/daughter, _____to participate in athletics at _____ School.**

_____ _____
**Parent/Guardian Signature** **Date**

_____
**Print Name**

_____ _____
**Athlete's Signature** **Date**

_____
**Print Name**

# Quitting a Sport

## Introduction

The Lafourche Parish School Board is opposed to quitting, regardliess of each person's physical abilities. We are committed to the idea that every player in our athletic programs makes an important contribution to the team's success and that when a player quits, he/she deprives the team of that contribution.

## Policy

If a player decides to quit; however, we ask that he/she meets first with the head coach to discuss his/her decision. After the meeting, appropriate action will be taken.

## Reinstatement

Players who quit a sport will be allowed to petition for reinstatement; such reinstatement will be determined by the head coach and athletic director. The reinstatement process will include the athlete meeting with both the head coach and athletic director. After this meeting, the head coach and athletic director will make a dicision, as to whether or not, to allow a player to return as a member of the team. Parents and athletes must understand that if a player violated the Code of conduct prior to or during the quitting process, the athlete will be held accountable to the Athletic Handbook Policies provided he/she is reinstated. Also, the decision made by the head coach and athletic director is FINAL.

## A Final Word

Every player on a Lafourche Parish team is very important to us. We believe that our job involves more than developing a winning program. Therefore, we encourage every player to remain as a contributing member of the team and to talk to coaches before making a decision to quit.

**I have read and understand the policy and procedures for Quitting A Sport. I also understand that if I have any questions concerning the policy and procedures, I must contact the athletic director before my child tries out or participates in a sport.**

_____ _____

**Parent's Signature** **Athlete's Signature**

_____

**Date**

# 2020-2021 Student Accident Coverage

Serviced by: **K&K Insurance Group, Inc.** Phone: 855-742-3135

***Remember to visit our website for faster enrollment:*** **www.studentinsurance-kk.com**
**Online Enrollment—Secured Accident Coverage can be purchased any time throughout the year.**

**ACCIDENT ONLY COVERAGE:** The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury. Provided that treatment by a qualified, licensed Physician begins within 60 days from the date of Injury, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date of Injury up to the Maximum Benefit per service as shown below.

**SCHEDULE OF BENEFITS:** *Maximum Benefits Paid As Specified Below. Medically Necessary and Reasonable Charges are based on the 75th percentile.*

| **Compare and Choose** | **Low Option Accident Only** | **High Option Accident Only** |
|---|---|---|
| Maximum Benefit: | $25,000 (For Each Injury) | $25,000 (For Each Injury) |
| Deductible: | $0 | $0 |
| ***Inpatient*** | | |
| Room & Board: | Up to $150 per day/<br>Semi-private room rate | 80% of Reasonable Charges/<br>Semi-private room rate |
| Hospital Miscellaneous: | $600 maximum per day | $1,200 maximum per day |
| Registered Nurse: | 75% of Reasonable Charges | 100% of Reasonable Charges |
| Physician's Visits:<br>*(Benefits are limited to one visit per day and do not apply when related to surgery)* | $40 first day/$25 each subsequent day | $60 first day/$40 each subsequent day |
| ***Outpatient*** | | |
| Day Surgery Miscellaneous: | $1,000 maximum | $1,200 maximum |
| Physician's Visits:<br>*Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)* | $40 first day/<br>$25 each subsequent day | $60 first day/<br>$40 each subsequent day |
| Outpatient Physical Therapy:<br>*(Benefits are limited to one visit per day)* | $30 first day/$20 each subsequent day/<br>5 days maximum | $60 first day/$40 each subsequent day/<br>5 days maximum |
| Emergency Room Services:<br>*(Treatment must be rendered within 72 hours from the time of the injury)* | $150 maximum | $300 maximum |
| X-Rays: | $200 maximum | $600 maximum |
| Diagnostic Imaging Services: | $300 maximum | $600 maximum |
| Laboratory: | $50 maximum | $300 maximum |
| Prescription Drugs: | $75 maximum | $200 maximum |
| Injections: | No Benefits | No Benefits |
| Orthopedic Braces & Appliances: | $75 maximum | $140 maximum |
| **Inpatient and/or Outpatient** | | |
| Surgery Fees: | $1,000 maximum | $1,200 maximum |
| Anesthetist: | 20% of Surgery Allowance | 25% of Surgery Allowance |
| Assistant Surgeon: | 20% of Surgery Allowance | 25% of Surgery Allowance |
| Ambulance: | $300 maximum | $800 maximum |
| Consultant: | $200 maximum | $400 maximum |
| Dental Treatment due to Injury to Teeth:<br>*(For Injury to sound, natural teeth only)* | $10,000 maximum per policy term | $10,000 maximum per policy term |
| Replacement of Eye Glasses, Contact Lenses or Hearing Aids that are broken as a result of a Covered Injury: | 100% of Reasonable Charges | 100% of Reasonable Charges |
| Durable Medical Equipment: | No Benefits | No Benefits |
| Maternity: | No Benefits | No Benefits |
| Complication of Pregnancy: | No Benefits | No Benefits |

**Expenses for the following are not covered:** Prosthetic Devices, Mental and Nervous Disorders, Home Health Care, Injections.

*This policy contains an excess provision. Benefits will not be paid under the Basic Accident Medical Expense for Covered Expenses to the extent that they are collectible under another Health Care Plan.*

*Details of these benefits may be found in the Master Policy on file at the School District.* ***NOTE:*** *This is a brief summary of the benefits and not a contract. A Master Policy has been provided to your school district that contains all of the provisions, limitations and exclusions and qualifications of the insurance benefits. The Master policy is the contract and will govern and control the payment of benefits.*

## Choose Your Coverage Plan: *One-Time Payment For Accident Coverage*

**PLEASE NOTE - FOR COVERAGE PLANS LISTED BELOW**

***Coverage Effective Date:*** A person's coverage takes effect at the later of the date his or her completed application and premium is received by the company or the effective date of the policy issued to his or her school or school district.

***Coverage Termination Date:*** Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year. All coverage ceases if the policyholder cancels the policy or when the person ceases to be eligible. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

| | Low Option | High Option |
|---|---|---|
| ***24-Hour Accident (Students & Employees)***<br>Around-the-clock/anywhere in the world. Before, during and after school. Weekends, vacation and all summer including summer school. School sponsored and extracurricular sports excluding High School Football. | $105.00 | $154.00 |
| ***24-Hour Accident (Summer Only Coverage, Students Only)***<br>Summer begins on the first day after the school year ends.<br>Summer ends the first day of the next school year. | $36.00 | $48.00 |
| ***At-School Accident (Students & Employees)***<br>During the regular school term, on school premises while school is in session. Direct and uninterrupted travel to and from home and scheduled classes. School Sponsored and supervised activities and sports excluding High School Football. Travel to and from school sponsored and supervised activities and sports while in a school furnished or approved vehicle. | $29.00 | $37.00 |
| ***High School Football (Full Year)***<br>Play or practice of regularly scheduled football. Consult your Athletic Department for enrollment instructions. | $171.00 | $284.00 |
| ***High School Football (Spring Only Rates)***<br>For new players who participate in spring training and not already insured under Football Coverage. Sports seasons are defined by your state high school athletic association. | $74.00 | $120.00 |
| ***High School Football and At-School Accident (Covers all athletics)*** | $200.00 | $321.00 |
| ***High School Football and 24-Hour Accident (Covers all athletics)*** | $276.00 | $438.00 |

## Facts about the Policy

1. WHO IS ELIGIBLE: students of the policyholder who make the required premium contribution for the coverage selected are eligible. Student status continues after graduation and between school years unless the person enrolls at a different school district.
2. The Master Policy on file with the school district is a non-renewable policy.
3. This is a limited benefit policy.
4. COVERAGE EFFECTIVE DATE: A person's coverage takes effect at the later of the date his or her completed application and premium is received by the company or the effective date of the policy issued to his or her school or school district.
5. COVERAGE TERMINATION DATE: Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year.
   All coverage ceases if the policyholder cancels the policy or when person ceases to be eligible. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.
6. LATE ENROLLMENT: Coverage may be purchased at any time during the school year. There is no premium reduction for any individual who enrolls late in the year
7. CANCELLATION: Coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company. However, a pro-rata refund of premium shall be made in the event a Covered Person enters the Military Service.
8. STUDENT TRANSFER: The policy continues to be in force anywhere in the world if the Covered Person should relocate prior to the expiration of coverage.

*1731(AOS_MB_ENG_03/20)*

## Enroll online at:

## *www.StudentInsurance-kk.com*

**or by mail using attached enrollment form.**

1. Complete and detach the enrollment form.
2. Make check or money order payable to Nationwide Life Insurance Company. Do not send cash. The Company is not responsible for cash payments.
3. Write your child's name on your check or money order.
4. Mail completed enrollment form with payment back to:
   ***K&K Insurance Group,***
   ***P.O. Box 2338***
   ***Fort Wayne, IN 46801-2338***
5. Your cancelled check, credit card billing, or money order stub will be your receipt and confirmation of payment.
6. Keep this brochure for future reference. Individual policies will not be sent to you.

### Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information.

### Administered by:

K&K Insurance Group, P.O. Box 2338,
Fort Wayne, IN 46801-2338

*Cut out card and retain for your records*

### STUDENT INSURANCE CARD

Student's Name_____

*If premium has been paid, the student whose name appears above has been insured under a Policy issued to:*

School District:_____

Accident Only Coverage: ❑ 24-HOUR ❑ 24-HOUR (Summer Only Coverage)
❑ AT-SCHOOL ❑ FOOTBALL ❑ FOOTBALL (Spring Only)

Paid by Check #_____ Amount Paid:_____ Date Paid:_____

Policy #_____

Underwritten by: Nationwide Life Insurance Company
**Claims Questions: K&K Insurance Group, Inc.**
**1712 Magnavox Way • Fort Wayne, IN 46801 • 800-237-2917**

## Policy Exclusions and Limitations for Accident Only Coverages

The following exclusions apply to any and all Benefits and any applicable Riders, unless otherwise specifically referenced. ***We will not pay Benefits for:***

1. An Injury or Loss that is:
   a. caused by war or any act of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of military nature (which does not include acts of terrorism);
   b. caused while the Insured is serving full-time active duty (more than 31 days) in any Armed Forces;
   c. caused by participating in a riot or violent disorder;
   d. the result of an Insured's taking part in committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act;
   e. the result of the Insured being under the influence of any drug, narcotic, intoxicant or chemical (unless prescribed by a Physician and taken according to the Physician's instructions) as defined by the law of the jurisdiction in which the Accidental Injury occurred. Conviction is not necessary for determination of being "under the influence."; or
   f. intentionally self-inflicted, including suicide or attempt thereof, while sane or insane.
2. An Injury or Loss that is the result of travel or flight (including getting in or out, on or off) in any aircraft except solely as a fare-paying passenger in a commercial aircraft, or as a passenger in a Policyholder chartered aircraft, provided such aircraft has a valid and current airworthiness certificate and is operated by a duly licensed or certified pilot, and while such aircraft is being used for the sole purpose of transportation and such travel is listed as a Covered Activity in the Schedule of Benefits.
3. Any Accident where the Insured is the operator and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
4. An Accident that occurs while:
   a. participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;
   b. riding, driving, or testing a motorized vehicle used in a race or speed contest, sport, exhibition work or test driving. Motorized Vehicle for purposes of this provision means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATV's, snow mobiles, tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. Motorized Vehicle does not include a Medically Necessary motorized wheelchair, unless such activity is specifically listed as a Covered Activity in the Schedule of Benefits.
5. Medical or surgical treatment, diagnostic or preventative care of any Sickness, except for treatment of pyogenic infection that results from an Accidental Injury or a bacterial infection that results from the Accidental ingestion of contaminated substances.
6. Any Heart or Circulatory Malfunction, whether or not known or diagnosed, except as may be otherwise covered under the Policy or unless the immediate cause of such malfunction is external trauma.

## Additional exclusions for the Accident Medical Expense Benefit and any applicable Riders: *We will not pay Benefits for:*

1. Expenses Incurred for services or treatment rendered by a Physician, Nurse or any other Provider who is:
   a. employed or retained by the Policyholder, or its subsidiaries or affiliates;
   b. the Insured, or the Insured's Family Member.
2. Expenses Incurred for charges which the Insured would not have to pay if he/she did not have insurance or for which no charge is made.
3. Expenses Incurred for charges which are in excess of Reasonable Charges.
4. That part of medical expenses payable by any automobile insurance Policy without regard to fault.
5. Expenses Incurred for any treatment that is considered to be experimental by the American Medical Association (AMA) or the American Dental Association (ADA).
6. Expenses Incurred for the examination, prescription, purchase, or fitting of eyeglasses, contact lenses, or hearing aids, unless Injury has caused impairment of sight or hearing or unless repair or replacement of existing eye glasses, contact lenses or hearing aids is necessary as a result of a covered Injury.
7. Expenses Incurred for new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except as a result of Injury up to the Dental Maximum shown in the Schedule of Benefits, if applicable.
8. Expenses Incurred for personal comfort or convenience items including, but not limited to, Hospital telephone charges, television rentals, or guest meals.
9. Expenses Incurred for or in connection with Custodial Care, unless otherwise specified in the Schedule of Benefits.
10. Expenses Incurred for supervision of an anesthetist.
11. Expenses Incurred for Durable Medical Equipment rental in excess of the purchase price.
12. Expenses Incurred for subsequent repairs and replacement of prosthetic devices.
13. Expenses Incurred for any condition covered by any Workers' Compensation Act, Occupational Disease law or similar law.

## Accident Only Definitions:

**Injury** A bodily injury which is:
1. directly and independently caused by specific Accidental contact with another body or object;
2. a source of loss that is sustained while the Insured Person is covered under this Policy and while he or she is taking part in a Covered Activity.

For all Benefits, Injury includes Heart and Circulatory Malfunction, subject to the following conditions:
1. Malfunction must occur before age 65 while the Insured is taking part in a Covered Activity; and
2. The symptom(s) of such malfunction(s) is (are) first medically treated while the Policy is in force with respect to the Insured and within 48 hours of having taken part in a Covered Activity; and
3. Such Insured has not, within one year prior to the date of participation in the Covered Activity, been medically diagnosed with, or received any medication for, any myocardial infarction, angina pectoris, coronary thrombosis, hypertension, heart attack, or a cerebral vascular incident.

For the Accident Medical Expense Benefit, Injury also includes repetitive motion injuries resulting from participation in a Covered Activity. Repetitive motion injuries are injuries such as, but not limited to, strains, sprains, hernias, tennis elbow, tendonitis, bursitis, and muscle tears. The repetitive motion injury must be diagnosed by a Physician and occur within 30 days of participation in a Covered Activity.

All Injuries sustained in one Accident, including all related conditions and recurrent symptoms of these Injuries will be considered as one Injury.

## Accidental Death & Specific Loss Benefits:

The Aggregate Limit is $500,000 and is the maximum amount payable for claims incurred for all Insureds under the Policy which are caused by any one Incident that occurs when the Policy is in force. If this limit is not sufficient to pay the total of all such Claims, then the Benefit payable to any one Insured will be determined in proportion to our total aggregate limit of liability. This Aggregate Limit of Liability applies only to Accidental Death and Specific Loss Benefits.

| | |
|---|---|
| Life | $10,000 |
| Both arms or both legs | $10,000 |
| Both hands and both feet | $10,000 |
| One arm and one leg | $10,000 |
| One hand and one foot | $10,000 |
| Either both hands or both feet | $10,000 |
| Speech and hearing in both ears | $10,000 |
| The sight of both eyes | $10,000 |
| The sight of one eye and either one hand or one foot | $10,000 |
| Either one arm or one leg | $7,500 |
| Either one hand or one foot | $5,000 |
| Speech or hearing in both ears | $5,000 |
| Sight of one eye | $5,000 |
| Hearing in one ear | $2,500 |
| Both the thumb and index finger of one hand | $2,500 |

# Enroll online for quicker service at www.StudentInsurance-kk.com

or complete and mail this form

## Enrollment Form (School Year 2020-2021)

Student's Last Name:_____

Student's First Name:_____

Student's Middle Name:_____ Date of Birth:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Name of School District (required):_____

Name of School:_____

Grade Level: ❑ Pre-K/Headstart ❑ Kindergarten/Elementary ❑ Middle School ❑ High School/Above

Signature of Parent or Guardian:_____

Date:_____ Email Address:_____ Phone Number:_____

## Student Insurance Plan Options — *Check Your Selection:*

| Accident Only Coverage Plans | Low Option | High Option |
|---|---|---|
| 24-HOUR | ❑ $105.00 | ❑ $154.00 |
| 24-HOUR Summer Only | ❑ $36.00 | ❑ $48.00 |
| AT-SCHOOL | ❑ $29.00 | ❑ $37.00 |
| HIGH SCHOOL FOOTBALL COVERAGE Full Year | ❑ $171.00 | ❑ $284.00 |
| HIGH SCHOOL FOOTBALL COVERAGE Spring Only *For New Players* | ❑ $74.00 | ❑ $120.00 |
| HIGH SCHOOL FOOTBALL and AT-SCHOOL *Covers all athletics* | ❑ $200.00 | ❑ $321.00 |
| HIGH SCHOOL FOOTBALL and 24-HOUR *Covers all athletics* | ❑ $276.00 | ❑ $438.00 |

**Enclose check for total payment payable to: Nationwide Life Insurance Company.** Checks, money orders, or credit cards accepted.
**DO NOT SEND CASH**
TOTAL ENCLOSED: $_____

*1731(AOS_MB_ENG_03/20)*

**Mail this completed form with payment back to:** ***K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338***

**Complete this section only if you wish to pay with a Credit Card**

*Full name as it appears on card*
First Name:_____ MI:_____ Last Name:_____
Billing Address *(if different than above)*
Street #_____ Address_____ Apt #_____

City:_____ State:_____ Zip:_____
Card Number: | | | | | | | | | | | | | | | | Expiration Date: Month: | | Year: | | | |

Cardholder signature:_____

Company does not issue refunds nor accept responsibility for cash payments. (Rejection of check or credit card by bank for any reason, will invalidate insurance.)

## Sports Participation Agreement Summary

_____I have carefully read the athletic participation handbook and will abide by all its rules and regulations and have completed all sections within this agreement to participate in interscholastic sports.

_____I have truthfully and comprehensively supplied all of the information covering student athlete and parent/guardian information. I have truthfully and comprehensively complete the emergency contact information.

_____I have carefully read the risks and dangers of all interscholastic sports participation. I understand the serious nature of those risks. I voluntarily assume all such risks, and I hereby waive all claims of any nature related to athletic particpation.

_____I have also carefully read and signed all necessary forms regarding the student-athlete's sports participation.

The necessary forms are:

| Form | Middle School | High School |
|---|---|---|
| LHSAA Medical History Evaluation | X | X |
| Parent or Guardian Consent, Indemnity, and Insurance Election | X | X |
| Emergency Information | X | X |
| Risk Acknowledgement | X | X |
| Drug Screening Consent | X | X |
| Concussion Statement | X | X |
| The Risk of Concussion and Head Injury | X | X |
| Quitting A Sport | X | X |
| LPSB Student Accident Coverage | X | X |
| Sports Participation Agreement Survey | X | X |
| LHSAA Substance Abuse Agreement | | X |
| LHSAA Athletic Participation/Parental Permission | | X |

I fully understand and voluntarily agree to the terms therein.

_____ _____

Signature of Parent/Guardian Signature of Parent/Guardian

_____

Date

# 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: _____ _____
Principal

Dated: _____ _____
Head Coach or AD

**1.10 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.

**1.10.1** 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.**

# 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 1.26.6 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.<br><br>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.<br><br>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) _____**