phone: (228) 467-7048

OUR LADY ACADEMY

222 South Beach Boulevard Bay St. Louis Mississippi 39520

ATHLETIC DEPARTMENT

STUDENT____

First Middle Last DOB

Dear PARENT/STUDENT:

OLA is planning to participate in nine interscholastic activities this year: cross country, volleyball, swimming, basketball, soccer, tennis, track, softball, and band.

A student who wishes to participate in any of the above-mentioned activities must have the **"Authorization of Parent/Guardian"** (below) filled out. She must also have the **"Authorization for Emergency Care to a Minor"** and **"Health Record/Doctor's Examination"** (both attached) filled out. A fee of fifteen dollars will be collected for the doctor's examination if the exam is given through arrangements made by OLA. **An Athletic Fee of one hundred fifty dollars will be required of the student's family to support the OLA Athletic Programs.** Student may choose to sell tickets to the annual Booster Club raffle to cover the athletic fee. If you choose not to sell the tickets, the check will be made out to the OLA Booster Club. The Booster Club payment is due at the time the forms are turned into the school. The exam fee will be due at the time of the exam.

In filling out these forms please fill out all appropriate blanks and comply with relevant requests. In particular, would you kindly insure that **copies of insurance cards** (health) are attached. Also, in providing addresses, **do not give P.O. addresses.** All signatures should be original. Witnesses should be adults and persons other than parents of the student.

Pursuant to requirements of the Mississippi High School Activities Assn. each student must present for our inspection official birth certificates issued by appropriate governmental agencies, e.g., Bureau of Vital Statistics. (Hospital certificates and photo copies are not accepted.) We return these. This is a one-time requirement; students who have previously submitted birth certificates should not do so again.
OLA requires that students participating in these activities have school medical insurance.

AUTHORIZATION OF PARENT/GUARDIAN

I am a parent/guardian of the above-named student. She has my permission to participate in the following interscholastic activities. **Please clearly circle "YES"** for each activity below. Please note that circling "YES" does not mean that a student has to participate in these activities, it simply means she is authorized to do so. If NO is circled for an activity, the student does not have permission to participate in that activity.

Cross Country	Yes	No
Volleyball	Yes	No
Swimming	Yes	No
Band	Yes	No
Basketball	Yes	No
Soccer	Yes	No
Track	Yes	No
Softball	Yes	No
Tennis	Yes	No
Cheerleading (SSC)	Yes	No

____
Parent/Guardian Signature

____
Street Address

____
City **Zip**

____
Phone

TO STUDENT: You are responsible for checking all forms to insure that they are correctly completed. **Do not submit incomplete forms.**

(over)

OUR LADY ACADEMY
BAY ST. LOUIS, MISSISSIPPI

AUTHORIZATION FOR EMERGENCY CARE TO A MINOR

We, the undersigned parent(s) of______________________ a minor, do hereby authorize OUR LADY ACADEMY and/or ST. STANISLAUS HIGH SCHOOL as agent for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by the State of Mississippi, Louisiana, or Alabama. It is understood that this authorization is given in advance of any specific diagnosis or hospital care being required, but is given to provide authority and power on the part of OUR LADY ACADEMY and/or ST. STANISLAUS to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may *deem* advisable, if the parents are not available to make the decision themselves.

Students Name: _____________________________ Grade____ Soc. Sec#______________
Address____Home Phone #__________
Birth Date_____________Age______Last Tetanus/Diphtheria Booster__________________
Allergies to medicine or foods____
Any special medications or pertinent information_____________________________
(use back if necessary)
Parents/Legal Guardian______________________________Phone__________________
Address____
Bus. Phone_________________Employer_______________________________________
Occupation_________________Employer's Address__________________________________

MEDICAL INSURANCE

Primary Insurance Company____
Address____
ID. No_________Group No.____________
Name of Policy Holder________________________________Social Security #____________
Secondary Insurance Company____
Address____
Name of Policy Holder___________________________Social Security#________________
ID.No_________________Group No.____________

Family Physician____

Father's Signature______________________________ Date____________________
Witness____ Date____________________

Mother's Signature______________________________Date____________________
Witness____**Date**____________________

PLEASE BE SURE TO ATTACH A COPY OF YOUR INSURANCE CARD TO THIS FORM

OUR LADY ACADEMY

HEALTH RECORD/DOCTOR'S EXAMINATION

This document is kept by the OLA Athletic Department. Its purpose is to insure that a student is physically fit to participate in athletics/activities sponsored by Our Lady Academy and/or St Stanislaus, and to record information which may be helpful to an attending physician in the event of an emergency.

Student's Full Name____
Last First Middle

Part 1 (to be completed by Parents) Grade__________

Please answer Yes or No. Give date. Has student ever had or does she have.

YES NO DATE | YES NO DATE

Scarlet Fever________________________ Ear/Throat Trouble________________________

Diptheria________________________ Asthma, Hay fever________________________

Rheumatic Fever________________________ Tuberculosis________________________

Fainting, Epilepsy________________________ Rupture, Hernia________________________

Convulsions________________________ Appendicitis________________________

Mumps________________________ Diabetes________________________

Eye Trouble________________________ Nervous Disorders________________________

Heart Murmurs________________________ Excess Bleeding________________________

Liver Disorders________________________ Chicken Pox________________________

Bone injury________________________ Surgery________________________

Accidents________________________ Measles________________________

Allergies/Treatment________________________ Other________________________

Student has had the following immunizations:

Tetanus Toxoid_____ Date ____________ Polio ______ Date ____________

Student has had unusual reaction: Tetanus antitoxin____________Penicillin____________

Mycin__________ Sulfa____________ Other______________
(e.g. Codeine, iodine)

Using special medicines____

X________________________________ ________________________
Parent's Signature Date

Part 2 (to be completed by Physician)

Height: ___ ft ___ inches Weight: ______ lbs Pulse: ______ B/P ______

Vision: Right 20/______. Left 20/______

Norm Abnorm Comments

Heart____

Lungs____

Back & Extremeties____

Throat____

Lymph Glands____

Thyroid____

Teeth____

Hearing____

Abdomen____

Neurological____

Urinalysis Sp Gr__________Alb________Sugar__________Micor____________________

The following is recommended: Eye refraction__________Audiometer Test______________

Recommended Special Medicines or Special Care________________________________

I have conducted a limited physical exam of the student named above and within the scope of this exam have found no obvious reason that the student may not participate in the school athletic program.

X________________________________ ________________________
Physician's Signature Date

Physician's Address City, State Phone #

MISSISSIPPI HIGH SCHOOL ACTIVITIES ASSOCIATION, INC.

Concussion Information Form

(Required by MHSAA Annually)

A concussion is a brain injury and all brain injuries are serious. They are 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. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, <u>all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly</u>. In other words, even a "ding" or a bump on the head can be serious. You cannot 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 symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms 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
"Don'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:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays incoordination
- 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

(Continued on next page)

<u>What can happen if my child keeps on playing with a concussion or returns too soon?</u>

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs,

particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is key to a student-athlete's safety.

MHSAA Concussion Policy:

- An athlete who reports or displays any symptoms or signs of a concussion in a practice or game setting should be removed immediately from the practice or game. The athlete should not be allowed to return to the practice or game for the remainder of the day regardless of whether the athlete appears or states that he/she is normal.
- The athlete should be evaluated by a licensed, qualified medical professional working within their scope of practice as soon as can be practically arranged.
- If an athlete has sustained a concussion, the athlete should be referred to a licensed physician preferably one with experience in managing sports concussion injuries.
- The athlete who has been diagnosed with a concussion should be returned to play only after full recovery and clearance by a physician. Recovery from a concussion, regardless of loss on consciousness, usually take 7-14 days after resolution of all symptoms.
- Return to play after a concussion should be gradual and follow a progressive return to competition. An athlete should not return to a competitive game before demonstrating that he/she has no symptoms in a full supervised practice.
- Athletes should not continue to practice or return to play while still having symptoms of a concussion. Sustaining an impact to the head while recovering from a concussion may cause Second Impact Syndrome, a catastrophic neurological brain injury.

Remember, it is better to miss one game than to miss the whole season.

I have reviewed this information on concussions and am aware that a release by a medical doctor is required before a student may return to play under this policy.

________________________ ________________________ __________
Student-Athlete Name Printed Student-Athlete Signature
Date

________________________ ________________________ __________
Parent Name Printed Parent Signature
Date