Lafourche Parish School Board

Athletic Participation Packet
2025 – 2026

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

IMPORTANT: This form must be completed *annually*, kept on file with the school, and 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 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) or the associated medical personnel. ……**Yes** **No**

_____ _____ _____

Date Signed by Parent **Signature of Parent** **Typed or Printed Name of Parent**

Health Care Provider section on page 2

IMPORTANT: This form must be completed *annually*, kept on file with the school, and is subject to inspection by the Rules Compliance Team.

Name:_____ Date of Birth:_____ Age:_____ Date:_____
School:_____ Grade:_____Sport(s):_____

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	☐	☐

ORTHOPAEDIC EXAM :

I. Spine / Neck

	Norm	Abnl
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐

II. Upper Extremity

	Norm	Abnl
Shoulder	☐	☐
Elbow	☐	☐
Hand / Fingers	☐	☐
Wrist	☐	☐

III. Lower Extremity

	Norm	Abn
Knee	☐	☐
Hip	☐	☐
Ankle	☐	☐

Health Care Provider notes (if needed):_____

[ ] Medically eligible for all sports without restriction

[ ] Medically eligible for certain sports_____

[ ] Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of _____

[ ] Not medically eligible pending further evaluation

[ ] Not medically eligible for any sports

This recommendation is from a limited screening.

_____	_____	_____
Printed Name of MD, DO, APRN or PA	**Signature of MD, DO, APRN or PA**	**Date of Medical Examination**

Revised 5/23 **This physical expires 13 months from the date it was signed and dated by the MD, DO, APRN or PA.**

Parent or Guardian Consent, Indemnity, and Insurance Form

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/Guardian Signature _____ **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 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** _____

Athletics Risk Acknowledgement

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 are 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 Signature **Student Athlete Signature**

_____

Date

Drug Screening Policy and Consent

Effective May 3, 2023, Policy IDFAA – Drug Screening of Student Athletes, will be implemented. The complete policy can be found on the Lafourche Parish School Board website. The following is an excerpt from Policy IDFAA:

Based on the process outlined below and the availability of funding, all student athletes may be required to submit to a drug screening on a date set by the Superintendent or designee 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 Superintendent or designee subject to the following guidelines: Random tests may be scheduled as frequently as once a week, but not less than once a month, for the duration of the athletic season. The Superintendent or designee shall determine a method of random selection of student athletes to be tested. The contracted laboratory will select no more than 15% but no fewer than 5% of student athletes of a particular sport.

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/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/headsup

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, regardless 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/Guardian Signature **Student Athlete Signature**

_____

Date

2025-2026 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.*

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 Hospital Services		
Room & Board Expenses:	Up to $150 per day/ Semi-private room rate	80% of Usual and Customary Charges/ Semi-private room rate
Miscellaneous Expenses	$600 maximum per day	$1,200 maximum per day
Physician's Visits: *(Limited to one visit per day)*	$40 first day/$25 each subsequent day	$60 first day/$40 each subsequent day
Ambulatory Medical Center	$1,000 maximum	$1,200 maximum
Emergency Room Treatment: *(Treatment must be rendered within 72 hours from the time of the injury)*	$150 maximum	$300 maximum
Surgery: *(*Allowance is calculated: 100% of Usual and Customary Charges for the 1st procedure, 50% of Usual and Customary Charges for the 2nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/portals.)*	$1,000 maximum	$1,200 maximum
Assistant Surgeon	100% of Usual and Customary Charges *(*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.)*	100% of Usual and Customary Charges *(*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.)*
Anesthesia and its Administration	100% of Usual and Customary Charges *(*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.)*	100% of Usual and Customary Charges *(*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.)*
Outpatient		
Outpatient Physician Visits: *(Limited to one visit per day)*	$40 first day/$25 each subsequent day	$60 first day/$40 each subsequent day
Outpatient X-ray:	$200 maximum	$600 maximum
Outpatient Diagnostic Imaging Services:	$300 maximum	$600 maximum
Outpatient Laboratory:	$50 maximum	$300 maximum
Outpatient Physiotherapy: *(Limited to one visit per day. Includes acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)*	$30 first day/$20 each subsequent day/ 5 days maximum	$60 first day/$40 each subsequent day/ 5 days maximum
Ambulance Services: *(Air and Ground)*	$300 maximum	$800 maximum
Medical Equipment Rental: *(Includes Orthopedic devices)*	$75 maximum	$140 maximum
Dental Services:	$10,000 maximum per policy term	$10,000 maximum per policy term
Prescription Drugs:	$75 maximum	$200 maximum
Consultant:	$200 maximum	$400 maximum
Replacement of Eye Glasses, Contact Lenses or Hearing Aids:	100% of Usual and Customary Charges	100% of Usual and Customary Charges

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.

THIS IS A BLANKET ACCIDENT ONLY POLICY.

U.S. Insurance coverage is underwritten by AXIS Insurance Company under group policy form series number BACC-001-0909, et al. Coverage is subject to exclusions and limitations, and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth in the policy.
The amount of benefits provided depends upon the plan selected; the premium will vary with the amount of the benefits selected.
THIS INSURANCE DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE.
FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

(2158-LOUISIANA-MB-ENG-02/25)

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 student accident enrollment form 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 an eligible person per the definition below. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

	Low Option	High Option
24-Hour Accident Around-the-clock. Before, during and after school. Weekends, vacation and all summer including summer school. School sponsored and extracurricular sports excluding High School Football	$112.00	$165.00
24-Hour Accident (Summer Only Coverage) Summer begins on the first day after the school year ends. Summer ends the first day of the next school year.	$39.00	$51.00
At-School Accident 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 or sports excluding High School Football. Travel to and from school sponsored and supervised activities or sports while in a school furnished or approved vehicle.	$30.00	$38.00
High School Football (Full Year) Play or practice of regularly scheduled football.	$176.00	$293.00
High School Football (Spring Only Rates) 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.	$76.00	$124.00
High School Football and At-School Accident (Covers all athletics)	$206.00	$331.00
High School Football and 24-Hour Accident (Covers all athletics)	$288.00	$458.00

About Your Coverage

1. ELIGIBLE PERSONS: students of the policyholder who enroll and make the required premium contribution for the coverage selected are Eligible Persons under the Policy. Depending on the coverage selected, coverage may continue after graduation and between school years unless the person enrolls at a different school district.
2. The Master Policy is on file with the school district and is a non-renewable policy. The student coverage selected is non-renewable and requires the student to re-enroll each school year.
3. This is a limited benefit policy.
4. COVERAGE EFFECTIVE DATE: Insurance becomes effective for a student who enrolls and makes the required premium contribution on the latest of the following dates:
   a. the Policy Effective Date;
   b. the date the Company receives student's completed enrollment form and the required premium payment.

   In no event will insurance for the Eligible Person become effective before the Policy Effective Date.
5. COVERAGE TERMINATION DATE: Coverage ends on the earlier of the date: he or she is no longer an Eligible Person, the end of the 1 year coverage term or the date the School's policy ends. 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 for a Covered Accident that occurs before the termination date.
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: Your coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company.

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 AXIS 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) ❑ EXTENDED DENTAL

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

Policy #_____

Underwritten by: AXIS Insurance Company
Claims Questions: K&K Insurance Group, Inc.
P.O. Box 2338 • Fort Wayne, IN 46801-2338 • 800-237-2917

COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. injuries compensable under Workers' Compensation law or any similar law;
10. operating any type of vehicle or Conveyance while under the influence of alcohol or narcotics or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred;
11. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
12. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
13. aggravation, during a Covered Activity, of an injury the Insured Person suffered before participating in that Covered Activity unless the Company receives a written medical release from the Insured Person's Physician;
14. 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;
15. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury; or
16. benefits will not be paid for services or treatment rendered by any person who is:
    a. employed or retained by the Policyholder;
    b. living in the Insured Person's household;
    c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
    d. the Insured Person.

EXCLUDED EXPENSES

The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;
3. examination or prescriptions for, or purchase, repair or replacement of wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
4. repair or replacement of existing artificial limbs, eyes and larynx;
5. treatment of an injury resulting from a condition that the Insured Person knew existed on the date of a Covered Accident, unless the Company has received a written medical release from his Physician.

In no event will the Company's total payments for the Insured Person exceed the Total Maximum for all Accident Medical Benefits shown in the Schedule of Benefits.
Other Exclusions that apply to this Benefit are in the Common Exclusions Section.

ACCIDENT ONLY DEFINITIONS:

Covered Injury means Accidental bodily injury:

1. which is sustained by an Insured Person as a direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force;
2. which results directly and independently from all other causes from a Covered Accident; and
3. which occurs while such person is participating in a Covered Activity. The Covered Injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury.

Accident or Accidental: means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the Insured Person is covered under this Policy.

Covered Expenses: means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date treatment, service or supply that gave rise to the expense or the charge, was rendered or obtained.

Medically Necessary: means medical services that:

1. are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. are ordered by a Physician and performed under His care, supervision or order.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:

Covered Loss must occur within 365 days of the Covered Accident.
Not more than the Aggregate Limit of $500,000 will be paid for all Covered Losses, Covered Accidents and Covered Injuries suffered by all Insured Persons as the result of any one Covered Accident that occurs under one of the Conditions of Coverage. This Aggregate Limit is payable only once, should more than one Condition of Coverage apply, We will pay the greater amount. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person's loss to the total of all losses, multiplied by the Aggregate Limit.

COVERED LOSS	BENEFIT AMOUNT
Loss of Life	$10,000
Loss of Two or More Hands or Feet	$10,000
Loss of Sight of Both Eyes	$10,000
Loss of Speech and Hearing (in Both Ears)	$10,000
Loss of One Hand or Foot and Sight in One Eye	$10,000
Loss of One Hand or Foot	$5,000
Loss of Sight in One Eye	$5,000
Loss of Speech	$5,000
Loss of Hearing (in Both Ears)	$5,000
Loss of Hearing in One Ear	$2,500
Loss of Thumb and Index Finger of the same Hand	$2,500
Exposure and Disappearance	Included

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

or complete and mail this form

Student Accident Enrollment Form (School Year 2025-2026)

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	❑ $112.00	❑ $165.00
24-HOUR, Summer Only	❑ $39.00	❑ $51.00
AT-SCHOOL	❑ $30.00	❑ $38.00
HIGH SCHOOL FOOTBALL COVERAGE, Full Year	❑ $176.00	❑ $293.00
HIGH SCHOOL FOOTBALL COVERAGE, Spring Only *For New Players*	❑ $76.00	❑ $124.00
HIGH SCHOOL FOOTBALL, and AT-SCHOOL *Covers all athletics*	❑ $206.00	❑ $331.00
HIGH SCHOOL FOOTBALL and 24-HOUR *Covers all athletics*	❑ $288.00	❑ $458.00

Enclose check for total payment payable to: AXIS INSURANCE COMPANY. Checks, money orders, or credit cards accepted.
DO NOT SEND CASH
TOTAL ENCLOSED: $_____

See IMPORTANT NOTICE - FRAUD WARNING on next page.

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.)

IMPORTANT NOTICE - FRAUD WARNING

- **In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **For Residents of Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.
- **For Residents of California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- **For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- **For residents of the District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- **For residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- **For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- **For residents of Maine, Tennessee and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- **For residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **For residents of New Hampshire:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
- **For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- **For residents of New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- **For residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- **For residents of Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- **For residents of Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- **For residents of Oregon:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- **For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- **For residents of Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- **For residents of Virginia:** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

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 informaiton.

_____ 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.

_____ _____

Parent/Guardian Signature **Student Athlete Signature**

_____

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. At the end of the year and prior to the next school year, a student shall must have **earned at least six units with an overall "C" average for the entire previous school year** as determined by the LEA in all units taken. All seniors must take at least four (4) subjects each semester. Special education students must consult the school principal, athletic director, or coach for scholastic information.
RESIDENCE AND SCHOOL TRANSFERS	Upon entering high school for the first time, a student shall have the choice to attend any member school located in the attendance zone in which the student resides with his/her parent(s)/guardian(s) or any other household with whom the student has been residing for the past calendar year and be immediately eligible unless an applicable exception applies. A transfer to another member school in the same attendance zone shall render the student ineligible for one calendar year.
UNDUE INFLUENCE	If a student shall has been recruited to a school for athletic purposes, he/she shall remain ineligible as long as the student attends that school.
AMATEUR	A student cannot play high school athletics if he/she loses their amateur status.
INDEPENDENT TEAM	In certain sports a student cannot play on a school team and an independent team during the same sport season.

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

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

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

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

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

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

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

PART II – PARENTAL PERMISSION

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

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

I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/ athletic director/principal of his/her school. Additionally, I give the LHSAA or it representative(s) permission to review my child's scholastic records and all required eligibility forms **however submitted by the school or myself**.

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

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

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

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

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

Date:_____ Parent's Signature: _____

Relationship to Student _____ (Print Name) _____

(Principal Signature) _____