

Iberville Renegades Tackle Football 2025

****Registration Deadline August 14, 2025****

Turn all documents listed below to the Parks & Rec office
TOGETHER – No Exceptions!

*Registration form

*\$40.00 registration fee

*Physical form completed by

(Medical Doctor MS, Osteopathic Dr. (DO), Nurse Practitioner (APRN), or Physician's Assistant (PA))

*Demographic Sheet/ School ID from the school that your child attends

*Emergency contact form

*Birth Certificate

Only 30 Players allowed per team!

Athlete Emergency Contact Form

COACHES PLEASE KEEP A COPY OF THIS IN TEAM BINDER AND RETURN TO IPRD

Student Athlete Information:

Name: _____

Address _____

City _____ Zip _____

Phone Number _____

Emergency Contact Information: Please provide information for primary and alternative contact persons who may be notified in case of an emergency.

Name of Primary Contact: _____

Relation: _____

Primary Phone: _____

Alternate Phone: _____

Email: _____

Alternative Contact: _____

Relation: _____

Primary Phone: _____

Alternate Phone: _____

Email: _____

Alternative Contact: _____

Relation: _____

Primary Phone: _____

Alternate Phone: _____

Email: _____

IPRD MEDICAL HISTORY EVALUATION
IMPORTANT: This form must be completed annually
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
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Sudden Death	_____	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait/Anemia	_____	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	_____

ATHLETE'S ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?

Yes	No	Condition	Date	Yes	No	Condition	Date	Yes	No	Condition	Date
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury / Concussion	_____	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury / Stinger	_____	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Elbow L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Arm / Wrist / Hand L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Back	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hip L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Thigh L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Knee L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Lower Leg L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Shin Splints	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ankle L / R	_____
<input type="checkbox"/>	<input type="checkbox"/>	Foot L / R	_____	<input type="checkbox"/>	<input type="checkbox"/>	Severe Muscle Strain	_____	<input type="checkbox"/>	<input type="checkbox"/>	Pinched Nerve	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chest	_____	Previous Surgeries: _____							

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur / Chest Pain / Tightness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma / Prescribed Inhaler	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual irregularities: Last Cycle: _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath / Coughing	<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight loss / gain
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Take supplements/vitamins
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Knocked out / Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Heat related problems
<input type="checkbox"/>	<input type="checkbox"/>	Single Testicle	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Recent Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Spleen
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait/Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Organ Loss (kidney, spleen, etc)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Overnight in hospital
<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Prescribed EPI PEN	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Food, Drugs) _____
<input type="checkbox"/>	<input type="checkbox"/>	Medications _____						

List Dates for: Last Tetanus Shot: _____ Measles Immunization: _____ Meningitis Vaccine: _____

PARENTS' WAIVER FORM

To the best of our knowledge, we have given true & accurate information & hereby grant permission for the physical screening evaluation. We understand the evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. We further understand that if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the team volunteer health-care provider and/or employer under Louisiana law.

This waiver, executed on the date below by the undersigned medical doctor, osteopathic doctor, nurse practitioner or physician's assistant and parent of the 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,

- If, in the judgment of an IPRD 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
- 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 director of the change immediately. Yes No
- I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/rep of his/her league. Yes No
- By my signature below, I am agreeing to allow my child's medical history/exam form and all eligibility forms to be reviewed by the IPRD 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	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>

(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	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>
II. Upper Extremity		
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>
Hand / Fingers	<input type="checkbox"/>	<input type="checkbox"/>
III. Lower Extremity		
Hip	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>

From this limited screening I see no reason why this student cannot participate in athletics.

- [] Student is cleared
[] Cleared after further evaluation and treatment for: _____
[] Not cleared for: __contact __non-contact

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

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

Iberville Parks and Recreation
2025 Tackle Football

Registration begins May 5 ends August 14, 2025

Registration Fee: \$40 per child – No Refunds

Bellevue Park
League Starts September 3, 2025
Practice Will Begin August 4th
Ages 5-12

Name: _____
(First) (Middle) (Last)

Address: _____
(House Number and Street) (City) (Zip Code)

Date of Birth: _____ Male: _____ Female: _____

School Grade _____ Age (as of December 31, 2024) _____

Parent/Guardian 1: _____ Parent/Guardian 2: _____

Cell: _____ Cell: _____

Email: _____ Email: _____

At least one email is required from either parent.

Pants Size (Circle One) YS (6-8) YM (10-12) YL (14-16) AS AM AL AXL AXXL

Compression Shirt Size YS (6-8) YM (10-12) YL (14-16) AS AM AL AXL AXXL

VOLUNTEER – ALL VOLUNTEER COACHES MUST PASS A
BACKGROUND CHECK <https://opportunities.averity.com/ibervilleparks>

Head Coach or Assistant Coach (Please circle one) Name _____

Shirt Size _____ Cell Number _____ Email _____

My undersigned signature confirms my understanding that participation in this leisure activity is on a voluntary, amateur basis and that there may be an element of risk involved. IPRD is not responsible for any injuries or accidents sustained and encourages all participants to obtain insurance for player protection. By acceptance of these conditions, I do, on behalf of myself, heirs, and legal representative, hereby release and forever discharge IPRD, and all its representatives from any and all claims and demands of every kind, nature, and character, for any and all damages. Losses, or injuries which may be sustained by the registrant in connection with any aspect of participation in this voluntary amateur activity.

Permission to Share images on social media (Please check one)

☐ I grant Iberville Parks and Recreation, the right to use registrant’s picture and/or likeness in printed, broadcast, web based, social media and other material concerning the program.

☐ I do not grant Iberville Parks and Recreation the right to use registrant’s image.

GUARDIAN’S SIGNATURE: _____
(Required for Child to Participate)

SIGN UP FOR TEXTS/EMAIL REMINDERS AT [PLAYIBERVILLE.COM](https://playiberville.com)
Visit website at [PLAYIBERVILLE.COM](https://playiberville.com) for Online Registration

Give us a call at (225) 687-0641 with any registration questions.
Mail to: IPRD P.O. Box 1060 Plaquemine, LA 70765

DO NOT SEND BACK TO SCHOOL