CCHS
Atlantic Medical Center, RHC

Consent for Minor's Sports Physical

I,_____ _____,
(Parent/Guardian Name) *(relationship to minor)*

authorize _____ to be able to come to Atlantic Medical Center, RHC,
(minor's name)

or any of its affiliates (Anita Medical Center, Griswold Medical Center, Massena Medical Center) for their sports physical that is needed for continuity of care for the minor listed above.

_____ _____
Parent/Guardian Signature *Date*

IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

ARTICLE VII 36.14(1) PHYSICAL EXAMINATION. **Every year each student (grades 7-12) shall present to the student's superintendent a certificate *signed* by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, qualified doctor of chiropractic, licensed physician assistant, or advanced registered nurse practitioner, to the effect that the student has been examined and may safely engage in athletic competition. *This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.***

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)

Student's Name _____ Male ___ Female ___ Date of Birth _____ Grade _____

Home Address (Street, City, Zip) _____ School District_____

Parent's/Guardian's Name _____ Date _____ Phone #_____

Family Physician _____ Phone # _____

HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the other side of this form after the examination.)

	Yes	No	Does this student have / ever had?
1.	_____	_____	Allergies to medication, pollen, stinging insects, food, etc.?
2.	_____	_____	Any illness lasting more than one (1) week?
3.	_____	_____	Asthma or difficulty breathing during exercise?
4.	_____	_____	Chronic or recurrent illness or injury?
5.	_____	_____	Diabetes?
6.	_____	_____	Epilepsy or other seizures?
7.	_____	_____	Eyeglasses or contacts?
8.	_____	_____	Herpes or MRSA?
9.	_____	_____	Hospitalizations (Overnight or longer)?
10.	_____	_____	Marfan Syndrome?
11.	_____	_____	Missing organ (eye, kidney, testicle)?
12.	_____	_____	Mononucleosis or Rheumatic fever?
13.	_____	_____	Seizures or frequent headaches?
14.	_____	_____	Surgery?
15.	_____	_____	Chest pressure, pain, or tightness with exercise?
16.	_____	_____	Excessive shortness of breath with exercise?
17.	_____	_____	Headaches, dizziness or fainting during, or after, exercise?
18.	_____	_____	Heart problems (Racing, skipped beats, murmur, infection, etc.?)
19.	_____	_____	High blood pressure or high cholesterol?
20.	_____	_____	Head injury, concussion, unconsciousness?
21.	_____	_____	Headache, memory loss, or confusion with contact?
22.	_____	_____	Numbness, tingling or weakness in arms or legs with contact?
23.	_____	_____	Severe muscle cramps or illness when exercising in the heat?
24.	_____	_____	Fracture, stress fracture or dislocated joint(s)?
25.	_____	_____	Injuries requiring medical treatment?
26.	_____	_____	Knee injury or surgery?
27.	_____	_____	Neck injury?
28.	_____	_____	Orthotics, braces, protective equipment?
29.	_____	_____	Other serious joint injury?
30.	_____	_____	Painful bulge or hernia in the groin area?
31.	_____	_____	X-rays, MRI, CT scan, physical therapy?
32.	_____	_____	**Has a doctor ever denied or restricted your participation in sports for any reason?**
33.	_____	_____	**Do you have any concerns you would like to discuss with your health care provider?**

	Yes	No	Family History:
34.	_____	_____	Does anyone in your family have Marfan syndrome?
35.	_____	_____	Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50?
36.	_____	_____	Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
37.	_____	_____	Has anyone in your family had unexplained fainting, seizures, or near drowning?
38.	_____	_____	Does anyone in your family have asthma?
39.	_____	_____	Do you or someone in your family have sickle cell trait or disease?

*Use this space to explain any **"YES"** answers from above (questions #1-38) or **to provide any additional information**:*

_____

_____

40. Are you allergic to any prescription or over-the-counter medications? *If yes, list:* _____

41. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
A. _____ B. _____ C. _____

42. Year of last known vaccination: Tdap (Tetanus): _____ Meningitis: _____ Influenza: _____

43. What is the most and least you have weighed in the past year? ***Most*** _____ ***Least***

44. Are you happy with your current weight? ***Yes*** _____ ***No*** _____ ***If no***, how many pounds would you like to lose or gain?
Lose _____ *Gain* _____

FOR FEMALES ONLY:

1. How old were you when you had your first menstrual period? _____

2. How many periods have you had in the last 12 months? _____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed medical professional as designated in Article VII 36.14(1).

Athlete's Name _____ Height _____ Weight _____

Pulse _____ Blood Pressure _____/_____ *(Repeat, if abnormal _____/_____)* Vision R 20/_____ L 20/_____

	NORMAL	***ABNORMAL FINDINGS***	***INITIALS***
1. Appearance (esp. Marfan's)			
2. Eyes/Ears/Nose/Throat			
3. Pupil Size (Equal/Unequal)			
4. Mouth & Teeth			
5. Neck			
6. Lymph Nodes			
7. Heart (Standing & Lying)			
8. Pulses (esp. femoral)			
9. Chest & Lungs			
10. Abdomen			
11. Skin			
12. Genitals - Hernia			
13. Musculoskeletal - ROM, strength, etc. *(See questions 24-31)*			
14. Neurological			

Comments regarding abnormal findings: _____

_____

_____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS

(Please be precise when indicating at which level the student is cleared to participate.)

1. _____ FULL & UNLIMITED PARTICIPATION

2. _____ LIMITED PARTICIPATION - *May **NOT** participate in the following (checked):*

_____ Baseball _____ Basketball _____ Bowling _____ Cross Country _____ Football _____ Golf _____ Soccer

_____ Softball _____ Swimming _____ Tennis _____ Track _____ Volleyball _____ Wrestling

3. _____ CLEARANCE PENDING DOCUMENTED FOLLOW UP OF _____

4. _____ NOT CLEARED FOR ATHLETIC PARTICIPATION DUE _____

_____ _____

Licensed Medical Professional's Name *(Printed)* **Date of PPE**

_____ _____

Licensed Medical Professional's Signature **Phone**

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I hereby **verify** the accuracy of the information on the opposite side of this form and **give my consent** for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I **also give my permission** for the team's physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury/illness and to share necessary information about the injury/illness with appropriate school personnel.

_____ _____

Name of Parent or Guardian, or student if 18 years of age *(Printed)* Signature of Parent of Guardian, or student if 18 years of age

_____ _____

Address (Street/PO Box, City, State, Zip) Phone Number

This form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for use by the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. Schools are encouraged NOT to change this form from its published format. Additional school forms can be attached to this form. *08/15*

CCHS
Atlantic Medical Center, RHC

Vaccine Update

For the convenience of you and your child, we will be offering immunization updates at the sport physical clinics this year.

We look at each child's immunization record to determine which vaccines are needed. If you have recently moved here or know that your child has had immunizations somewhere else besides Cass County Health System, please bring in documentation to update your records.

The most common vaccines for the 11-18 year old group are HPV (Gardasil); Tetanus, Diphtheria, and Pertussis (Tdap); Meningitis and Meningitis B; and Hepatitis A.

Want to Know More about Vaccines?

At www.immunize.org, you can read the Vaccine Information Statement (VIS) on all vaccines before receiving them. Click on the Vaccine Information Statements to learn more about each vaccine and what it protects against. We will also provide you or your child with a VIS before your child receives the vaccine.

Worried about the Cost of Vaccines?

Most private insurance companies and Medicaid cover the cost of childhood vaccines. We also participate in VFC (Vaccines for Children) program, which offers vaccines at low cost to families who qualify. At AMC, we don't want the expense of a visit or vaccines to stop you from coming in. If you have concerns, please call and talk to our Patient Financial Adviser at 712-250-8111. You may want to check with your insurance company a head of time to find out if they will or will not pay for the vaccines.

VFC
PRIVATE

Adolescent Vaccinations Consent

Record of immunization will be made in the IRIS (Immunization Registry Information Systems), the State of Iowa's Immunization Registry. Upon your request, we will share information regarding this vaccination. "I have received and read the Centers for Disease Controls' Vaccine Information Statement. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I understand that members of the Atlantic, Anita, Massena, and Griswold Medical Center will bill to the insurance coverage(s) provided below, but I am responsible for and will receive a statement for any amount that stated insurance does not cover. I understand that not filling out this form completely, clearly, and correctly may cause incorrect vaccination and billing. I request vaccines to be administered."

Choose vaccines to be administered (18yr or younger):

- ☐ HPV (Gardasil)
- ☐ Hepatitis A
- ☐ Tetanus with Pertussis (Tdap)
- ☐ Meningitis (Menactra)
- ☐ Meningitis +B (Bexsero)

Name: (Last)	(First)	(M.I.)	School:	Grade:

Address:	**Birthdate:** mm/dd/yyyy	**Age**:	**Gender**: (circle) MALE FEMALE

City:	**State:**	**Zip:**	**Parent Name & Daytime Phone:** Name: Phone:

Physician:	**Physician Office Name/Location:**	**Physician Office Number:**

Payment Method

- ☐ I have no insurance or my insurance does not cover immunizations (vaccination provide at no cost, donations welcome)
- ☐ I am American Indian or an Alaskan Native (vaccination provided at no cost, donations welcome)
- ☐ I have private insurance and want the bill submitted through my insurance plan

Insurance policy holder's name:	Policy holder's DOB:
Policy holder's address: City: State: Zip:	Insurance company name: ☐ United Health Care ☐ Cigna ☐ Blue Cross Blue Shield ☐ Other_____ ☐ Midlands Choice ☐ Hawk-I

Please look at your insurance card to complete the information below. You may provide a copy of your insurance card if you prefer.

Insurance policy number:_____ Insurance group number:_____

For clinic/office use ONLY:

Date vaccine administered:_____

Name of school: ATLANTIC MASSENA GRISWOLD ANITA

- ☐ HPV (90651)
- ☐ HEP A (90633)
- ☐ MENINGITIS (90734)
- ☐ Tdap (90715)
- ☐ MENINGITIS +B

Lot number: _____

Expiration Date:_____

Site of Injection: _____

Bill to:

- ☐ United Health Care
- ☐ Blue Cross Blue Shield
- ☐ Midlands Choice
- ☐ Hawk-I
- ☐ Cigna
- ☐ Other_____

Signature/Title of Vaccine Administrator: _____

IRIS entry done by:_____ Date: _____