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, advanced registered nurse practitioner (ARNP), physician's assistant or qualified doctor of chiropractic*, 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). ***This evaluation is only to determine readiness for sports participation. It should NOT be used as a substitute for regular health maintenance examinations.***

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

_____ **FULL & UNLIMITED PARTICIPATION**

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

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

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

_____ **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF**_____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE TO**_____

_____ _____

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 *(Printed)* Signature of Parent of Guardian

_____ _____

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. *06/14*

A FACT SHEET FOR PARENTS AND STUDENTS

HEADS UP: Concussion in High School Sports

The Iowa Legislature passed a new law, effective July 1, 2011, regarding students in grades 7 – 12 who participate in extracurricular interscholastic activities. Please note this important information from Iowa Code Section 280.13C, Brain Injury Policies:

(1) A child must be immediately removed from participation (practice or competition) if his/her coach or a contest official observes signs, symptoms, or behaviors consistent with a concussion or brain injury in an extracurricular interscholastic activity.
(2) A child may not participate again until a licensed health care provider trained in the evaluation and management of concussions and other brain injuries has evaluated him/her and the student has received written clearance from that person to return to participation.
(3) Key definitions:
"Licensed health care provider" means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.
"Extracurricular interscholastic activity" means any extracurricular interscholastic activity, contest, or practice, including sports, dance, or cheerleading.

What is a concussion?
A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

What parents/guardians should do if they think their child has a concussion?
1. **OBEY THE NEW LAW.**
   a. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
   b. Seek medical attention right away.
2. Teach your child that it's not smart to play with a concussion.
3. Tell all of your child's coaches and the student's school nurse about ANY concussion.

What are the signs and symptoms of a concussion?
You cannot see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

STUDENTS:
If you think you have a concussion:
- **Tell your coaches & parents –** Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up –** A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal –** If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

IT'S BETTER TO MISS ONE CONTEST THAN THE WHOLE SEASON.

Signs Reported by Students:
- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

PARENTS:
How can you help your child prevent a concussion?
Every sport is different, but there are steps your children can take to protect themselves from concussion and other injuries.
- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

Signs Observed by Parents or Guardians:
- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Information on concussions provided by the Centers for Disease Control and Prevention.
For more information visit: **www.cdc.gov/Concussion**

IMPORTANT: Students participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must annually sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.

We have received the information provided on the concussion fact sheet titled, "HEADS UP: Concussion in High School Sports."

Student's Signature _____ Date _____ Student's Printed Name _____

Parent's/Guardian's Signature _____ Date _____ Student's Grade _____ Student's School _____

May2012-CE

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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: _____