School Physical Checklist

- □ History Form completed and signed
- □ Immunization Consent Form completed and signed
- □ Conditions of Admissions and Authorization completed and signed
- □ Attach copy of insurance card
- □ Bring first morning urine sample
- □ Girls— do not wear sports bra to exam - scoliosis check

At the end of each physical the student will be given a "Medical Eligibility Form" and "Physical" form. Because of HIPAA, the parent decides what information will be shared with the schools beyond the eligibility form. We strongly encourage parents to share the entire physical form with the school in the interest of the health of their child. Particularly if your child has health concerns that the school nurse and /or coaches should be aware of.

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

* Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a comination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.

Parent or Legal Guardian Signature _____ *Date* _____

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

IMMUNIZATION CONSENT FORM

Please fill out this form if a parent/guardian will not be attending your child's school physical appointment and you would like your child to receive immunizations.

**Children without insurance may receive immunizations through the Vaccine for Children program at our facility.*

9-12 Years	13-15 Years	16-18 Years
• HPV (2 doses) • Meningococcal ACWY • Tdap	• Meningococcal ACWY (if not previously vaccinated)	• Meningococcal B • Meningococcal Booster

Gardasil is most effective at preventing, **Human papillomavirus (HPV)**, which can cause cancers in *both* boys and girls.

- Recommended for teens from 9-14 years of age. This includes 2 doses given 6-12 months apart.
- Teens 15 years of age and older will receive a 3 dose series with the 2nd dose given 1-2 months after the 1st and the 3rd does given 6 months after the 1st.

Menveo There are 5 vaccine-preventable **meningitis** groups. Menveo covers 4 of those groups (A, C, W, Y).

- Recommended for teens from 11-18 years of age. This includes 2 doses with the 1st given at 11-12 years of age and a booster shot at 16 years of age.

Bexsero This immunization covers the 5th group of **meningitis-B** – that was not included in the Menveo vaccination.

- Recommended for teens 16-23 years of age. This includes a 2 does series, with shots given 1 month apart.

Boostrix This immunization covers **tetanus, diphtheria, and pertussis (Tdap).**

- Recommended for teens 10 years of age and older.
- Needs to be updated every 10 years.

It is your responsibility to know if your insurance covers these immunizations, please call the number on the back of your card to verify prior to receiving the shot.

Child's Name_____ DOB_____

I authorize my child to receive the following immunizations:

- □ Gardasil (HPV)
- □ Menveo (Meningococcal ACWY)
- □ Bexsero (Meningococcal B)
- □ Boostrix (Tdap)

Printed Parent/Guardian Name_____

Number we can reach you the day of the appointment with any questions _____

_____ _____

Parent/Guardian Signature Date

CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT
Franciscan Healthcare

Medical Consent: I hereby acknowledge that I have (or, if signing on behalf of the patient, the patient has) a condition requiring medical treatment, do hereby voluntarily consent to such care encompassing routine diagnostic procedures and medical treatment by Franciscan Healthcare, my treating practitioner, his/her assistants, or his/her designees, including hospital personnel and telemedicine providers, as is determined necessary in his/her judgment. This consent is designed to cover all procedures in the hospital or clinic which do not require a specific consent form. For purposes of multiple visits to the clinic, I intend for this consent and agreement to remain effective for one (1) year. I understand that I have (or the patient has) the right to refuse treatment and that my signature below is not a consent to any non-routine or non-emergency procedure. The treating practitioner and/or a member of the nursing staff may ask me to sign a form consenting to special medical or surgical procedures. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in Franciscan Healthcare. Franciscan Healthcare encourages patients to insist on any additional information necessary to make an informed decision to consent to or refuse treatment. I acknowledge that some physicians and certain other practitioners providing services to me are private practitioners, and are not employees or agents of Franciscan Healthcare, and my consent and agreement herein applies to all such services provided at Franciscan Healthcare.

Notice of Medical Provider On-Site: Franciscan Healthcare does not have a physician present in the hospital 24 hours per day, 7 days per week. In the event you are admitted as an inpatient, observation patient, or outpatient surgery patient, be advised that Franciscan Healthcare has available on call a physician or an advanced practice provider serving the hospital to meet your medical needs. Although these medical providers are not in-house all of the time, they are readily available to meet your health care needs in accordance with federal regulations.

Continuing Clinic/Outpatient Care: In some cases, proper treatment of a medical condition requires treatment over the course of repeated clinic or outpatient visits. In such cases, the requests, consent, and agreements contained herein are valid and shall apply to all repeat visits and continuing treatment and diagnosis for the same condition, except for the elections related to electronic health information exchange, which will remain valid unless and until I change my designation in the manner described below.

Consent for Release of Medical Information: The hospital, clinic, physicians and other health professionals involved in my care may release my healthcare information necessary for treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on my behalf in order to verify coverage or payment questions or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation. The disclosures described in this section will be made in accordance with state and federal law and the Franciscan Healthcare's Notice of Privacy Practices.

Financial Agreement: I agree to promptly and fully pay all charges for services and supplies provided by Franciscan Healthcare, physicians and others providing services in accordance with their regular rates and terms. I hereby personally obligate the patient, and also personally obligate myself if signing as the patient, the patient's spouse, the parent of a minor patient, or the legal guardian of a patient, for payment of all such charges at the regular rates to the extent not covered by insurance, and agree to pay any charges which, for any reason, are not promptly paid by insurance. I agree, subject to state or federal law, to pay all costs, reasonable attorney fees, expenses, delinquent charges and interest, in the event Franciscan Healthcare has to take action to collect the same because of my failure to pay in full. I authorize Franciscan Healthcare to obtain one or more credit reports on the patient and/or me. I understand that it is my responsibility to obtain any prior approvals required by an insurer, and to take all other steps to qualify for insurance coverage; I will determine whether my insurer requires pre-certification before I receive services from Franciscan Healthcare. No extension or forbearance, no attempt to obtain payment from insurance or other sources and no delay or lack of diligence in collecting such charges shall waive or release the personal financial obligations hereunder.

Assignment of Insurance Benefits: I certify that the information given by me is correct. I hereby assign to Franciscan Healthcare, for services provided by Franciscan Healthcare and its employees or others working under contract or arrangement with Franciscan Healthcare, all coverage or other benefits under any governmental or private insurance policy, plan or program. I direct that all such benefits be paid directly to Franciscan Healthcare. For private physicians billing separately from Franciscan Healthcare, I assign coverage and benefits, and direct payment for their services provided to me, to such physicians. Any credit balance resulting from benefit payment or other sources may be applied to any other account owed by me or the undersigned to Franciscan Healthcare. This assignment specifically includes, but is not limited to, all benefits for all medical and hospitalization insurance; accident insurance; disability or loss-of-time insurance; Medicare, Medicaid, and CHAMPUS; benefits payable by alternative delivery systems such as HMOs and PPOs or arising from worker's compensation or occupation disease claims; and proceeds to which I am, or my estate is, entitled because of any judgment, settlement, or other claim or cause of action for damages if I was or am injured. This assignment may not be revoked as to services provided during this hospitalization or course of diagnosis and treatment. I also understand I am responsible for any amount not covered or paid by my insurance benefits.

Acknowledgement of Patient Rights and Responsibilities: I was given or offered information on patient rights and responsibilities.

Consent for Telemedicine: I hereby consent to the use of telemedicine services ordered by my attending physician or treating practitioner. I understand that the consulting provider will be at a different location from me. I can decline telemedicine services at any time without affecting or taking away either my right to future care/treatment, or any program benefits to which I would otherwise be entitled. If I decline the telemedicine service, alternatives will be discussed including but not limited to transfer to another facility. Franciscan Healthcare personnel will use real time video to transmit or share with the telemedicine provider necessary details of my medical history, examinations, x-rays, tests, photographs or other images. Neither video nor audio will be recorded during the consultation. No dissemination of patient identifiable images or information from the telemedicine consultation will be made to researchers or other entities without my written consent. The same confidentiality protections that apply to my other medical care also apply to the telemedicine service. I have all rights to access medical information resulting from the telemedicine consultation as provided by law.

Authorization of Communications from Franciscan Healthcare: I consent to contact by Franciscan Healthcare (or its assignee) by regular mail, by e-mail, text or by telephone (including a cell phone/wireless number) regarding any matter related to my account(s). This includes contact for the purpose of scheduling, education, telemarketing, debt collection, satisfaction surveys or other purposes. I consent for Franciscan Healthcare to use technology, including automated technology such as auto-dialing or pre-recorded messages, to contact me at the address, e-mail address, or telephone number, including any cell phone/wireless number, I have provided, or any updated or additional contact information I provide at a later time. If I discontinue use of any cell phone number provided, I shall promptly notify

Franciscan Healthcare. I hereby indemnify Franciscan Healthcare and its agents and independent contractors from any expenses or other loss arising from any failure to notify.

Image and Audio Recording Consent: I agree that medical images, photographs, audio recordings and digital or video recordings may be made while I am receiving care at Franciscan Healthcare. I understand that the images and audio from such photography and recording may be used for my treatment and these images and recordings will become part of my medical information subject to uses and disclosures as described in the Notice of Privacy Practices.

Preservation of Tissue: I hereby authorize Franciscan Healthcare to retain, preserve and use for scientific or teaching purposes or dispose of at its convenience, any specimens or tissue taken from my (or the patient's) body during any hospital/clinic procedure(s).

Nebraska Health Information Initiative (NEHII) and CommonWell: Franciscan Healthcare participates in NeHII (state-wide) and CommonWell (nationwide), which were developed to share information so that participating health care providers can quickly view my health information when caring for me. By signing below, I acknowledge that I have been offered education about NeHII and CommonWell, and I understand that patient information will be included in NeHII and CommonWell unless I choose to opt out.

Patient Directory: I understand that unless I object, my name and location within the hospital will be included in the patient directory, and this information will be given to those who ask for me by name. If I object to inclusion in the patient directory, visitors who ask for me by name will be informed there is nobody by that name in the patient directory, and calls, flowers, and mail will not be delivered to me. I understand that I may notify hospital personnel of my objection to inclusion in the directory at any time during my hospitalization.

Personal Valuables: Franciscan Healthcare maintains a safe for the safekeeping of money and valuables; and Franciscan Healthcare shall not be liable for the loss or damage to any personal property unless it is deposited with Franciscan Healthcare for safekeeping.

Advance Instructions for Health Care: I understand that I may indicate in writing, by an Advance Directive (i.e., Living Will or Durable Power of Attorney for Health Care), my desire to receive, select and/or define medical or surgical treatment or choose non-treatment. If my Advance Directives are provided to Franciscan Healthcare, a copy will be placed with my medical records, and Franciscan Healthcare will recognize such instructions consistent with Franciscan Healthcare policies.

Medicare Patients Only - Assignment and Certification: I request payment of authorized Medicare benefits on my behalf for any services furnished to me by or in Franciscan Healthcare. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I certify that the information I have provided to Franciscan Healthcare is true, accurate, and complete.

Medigap Patients Only - Assignment of Medigap Benefits: I request that payment of authorized Medigap benefits be made on my behalf to Franciscan Healthcare for any services furnished by it to me. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services. Until revoked, this authorization applies to all occasions of service. This assignment is specific to the supplemental insurance information provided during registration (see scanned copy of the insurance card for policy number).

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ OR HAS HAD READ TO HIM/HER THE FOREGOING, WAS OFFERED A COPY THEREOF, AND IS THE PATIENT, THE PATIENT'S LEGAL REPRESENTATIVE, OR ONE DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S AGENT TO SIGN AND AGREE TO THIS DOCUMENT. BY SIGNING BELOW, I CERTIFY THAT THIS "CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT" HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS.

Name of Patient (Print)	
Signature of Patient/Legal Guardian/Authorized Representative	Date
Relationship to Patient (if not Patient)	Reason Patient Unable to Consent
Signature of Witness	Date