FREE Sports Physical Day

Middle Park Health has partnered with East Grand School District to offer **FREE sports physical day July 23rd at Middle Park Health - Granby Clinic for all high school athletes.**

Appointments are not required but please come by the first letter of your last name during the following times

A-F 8am-9:45am | G-L 9:45am-11:30am
M-R 12:30pm-2:15pm | S-Z 2:15pm-4pm

During this sports physical day, athletes will complete their sports physical. Parent/guardian consent is required. Please sign the attached forms prior to July 23rd and send with your student if you are unable to attend sports physical day with them.

If you are not able to make it this day sports physicals will be offered at any Middle Park Health clinic location for $35.00. As always the school district can accept sports physicals completed by any primary care provider. If you do not attend one of the free sports physical days please be sure to send a copy of your sports physical to the school district.

Please contact Tiffany Freitag, Middle Park Health, Director of Business Development with any questions.
tfreitag@middleparkhealth.org

MIDDLE PARK HEALTH
Keeping Life Grand

MIDDLE PARK HEALTH
Keeping Life Grand

PATIENT REGISTRATION FORM

Last Name:	**First Name:**	**MI:**	**Preferred Name:**

Date of Birth:	Sex:	SSN:	Home Phone:

Physical Street Address:	Mailing Address:	Work Phone:

City:	State:	Zip:	Cell Phone:

Email Address:	Emergency Contact Name:	Phone #:	Relationship:

Primary Care Physician:

Preferred Pharmacy:	City:

Marital Status:	Primary Language Spoken:	Written:

Religion:	Communion:	Y N N/A

Birthplace (City/State):	Employer:	Full Time Part Time

Military Status: None Active Duty Reserve Active or Inactive Veteran

INSURANCE INFORMATION

Primary Insurance:

Subscriber's Name:	Date of Birth:

Name of Employer Providing Insurance:	

Patient's Relationship to Subscriber:	Self	Spouse	Child	Other

Secondary Insurance:

Subscriber's Name:	Date of Birth:

Name of Employer Providing Insurance:	

Patient's Relationship to Subscriber:	Self	Spouse	Child	Other

ADVANCE DIRECTIVES

Existing advance directives: Y/N	Power of Attorney	DNR	CPR Directives	Living Will	Other

Would you like to receive Advance Directives Information? Y/N

MIDDLE PARK HEALTH
Keeping Life Grand

PATIENT STICKER

SERVICE AGREEMENT

1. CONSENT FOR HEALTH CARE SERVICES. I voluntarily consent to and authorize the rendering of health care services, including but not limited to routine hospital services, clinic services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures which my attending physician or others holding clinical privileges consider necessary in person or telehealth. My healthcare provider will discuss with me the risks, benefits, and alternatives to the recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I further understand that the practice of medicine is not an exact science and I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in this health care facility. I understand that copies of my medical records may be sent to or shared with other practitioners, providers, healthcare facilities, as permitted by law. I understand that my rights and responsibilities with regard to my care are described in more detail on the Patient Bill of Rights document.

2. NON-MPMC PRACTITIONERS. I understand that many of the professionals, who provide care to me at Kremmling Memorial Hospital dba Middle Park Medical Center, henceforth will be referred to as MPMC, are not employees or agents of MPMC. These professionals may include my own physician, other physician requested by my physician to participate in my care as well as emergency department physicians, radiologists, pathologists and anesthesiologists. As a result, I understand that these professionals will bill me for charges that are separate from those of MPMC. I understand that, in some cases, these professionals may not be participating providers under my insurance plan. MPMC recognizes that this can be both frustrating and costly because I may be responsible for out of network costs or other costs because the professional does not have a contract with my insurance plan. I understand it is my responsibility for out of network costs or other costs because the professional does not have a contract with my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance.

3. MEDICARE and/or MEDICAID CERTIFICATION. I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to MPMC on my behalf for MPMC's and physicians' charges for which MPMC is authorized to bill in connection with these health care services.

5. FINANCIAL AGREEMENT. I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of MPMC and of physicians rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service or following the medical screening exam. Any remaining charges are due and payable upon receipt of the bill. If I do not have insurance or I cannot pay my bill, I may qualify for financial assistance. I understand that I may be required to submit documentation to determine my eligibility for financial assistance. I understand MPMC may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with MPMC. I consent to be contacted by regular mail, or by e-mail regarding any matter related to my account by MPMC or any entity to which MPMC assigns my account. I also consent to the use of any updated or additional contact information that I may provide by MPMC or any entity to which MPMC assigns to my account.

6. COMMUNICATIONS CONSENT. By providing my cell or other phone number(s), I expressly consent to receive communications from MPMC, its agents or business associates at any numbers I provide or that are later acquired, to be used to contact me by live agent, voice mail, text message, using an auto dialer or other computer- assisted technology, pre-recorded message, or by any other form of electronic communication for any purpose, including scheduling, notifications, confirmations, reminders, instructions, accounting, billing,

PATIENT STICKER

assignment of benefits, and/or collections. I understand that depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new numbers if my numbers change. Providing these numbers is not a condition of receiving healthcare services.

7. PREAUTHORIZATION REQUIREMENTS. I understand that it is my sole responsibility to obtain all pre-authorization and to comply with all requirements of any insurance or medical/hospital coverage plan upon which I am relying for coverage of MPMC's and physicians' charges.

8. ASSIGNMENT FOR DIRECT PAYMENT. I authorize and direct that payment of any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to MPMC and my physicians, to include any hospital-based radiologists, pathologists, anesthesiologists and emergency department physicians. I understand that I am financially responsible to MPMC or my physicians for charges not covered or paid pursuant to this authorization.

9. PERSONAL VALUABLES. MPMC maintains a safe for the safekeeping of any money or valuables. I understand that MPMC does not assume responsibility for the loss, damage, or disposal of my personal property or money including jewelry, clothing, dentures, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other item unless such money or property is deposited with MPMC. I take full responsibility for any money or property retained in my possession/room or brought to me while I am a patient at MPMC.

10. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES. I acknowledge that Middle Park Medical Center has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on the MPMC web-site. I understand this acknowledgement in no way affects the care I receive at MPMC.

By checking one of the boxes below, I acknowledge:

☐ **I accepted a copy of the Notice of Privacy Practices**

☐ **I declined a copy of the Notice of Privacy Practices**

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

SIGNATURE OF PATIENT OR LEGAL RESPONSIBLE PERSON

NAME (PRINT)

DATE _____ TIME _____

RELATIONSHIP/REASON WHY PATIENT IS UNABLE TO SIGN

MIDDLE PARK HEALTH
Keeping Life Grand

Release of Medical Records Form

Patient's Name: _____ Date of Birth: _____

Medical Record#: _____ Social Security #: _____

I hereby authorize:

Name: Middle Park Health

Address: PO Box 399

City: Kremmling State: CO Zip Code: 80459

To release healthcare information of the patient named above to:

Name: East Grand School District

Address: PO Box 125

City: Granby State: CO Zip Code: 80446

☐ Date & Time of Appointment _____7/23/2025_____

PURPOSE OF DISCLOSURE:
- ☐ Continuing Care
- ☐ Payment of Claim
- ☐ School
- ☐ Worker's Compensation
- ☐ Legal
- ☐ For Personal Use

(LAB ONLY)
RECORDS WILL BE:
- ☐ Picked up at Desk
- ☐ Mail to address above

All information regarding Alcohol and/or Drug Abuse will be released **unless you restrict** by initialing below:

☐ Other (specify): Sports Physical _____

INFORMATION TO BE RELEASED: Between Dates of: 4/30/2025

- ☐ Discharge Summary
- ☐ H&P Exam
- ☐ Consult
- ☐ Progress Notes/Provider Notes
- ☐ Orders
- ☐ Other (specify content and dates): Sports Physical
- ☐ X-ray reports
- ☐ X-ray films
- ☐ Diagnostic Tests
- ☐ Procedure reports
- ☐ Lab reports/pathology
- ☐ HIV/AIDS test

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one year from today's date.
- I understand that I may revoke this authorization at any time, in writing.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal regulations.
- I understand that NPMC-W may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

Patient Signature _____ Date _____

Signature of Authorized Person _____ Relationship to Patient _____

Fax To: (970)724-3211

MIDDLE PARK HEALTH
Keeping Life Grand

Forma de Absolución de Registros Médicos

Nombre del Paciente: _____ Fecha de Nacimiento: _____

de Registro Médico: _____ # de Seguro Social: _____

Por este medio yo autorizo:

Nombre: Middle Park Health

Dirección: PO Box 399

Ciudad: Kremmling Estado: CO Código Postal: 80459

A entregar la información de salud del paciente antes mencionado a:

Nombre: East Grand School District

Dirección: PO Box 125

Ciudad: Granby Estado: CO Código Postal: 80446

☐ Fecha y Hora de la Cita: _7/23/2025_____

PROPOSITO DE LA ENTREGA DE INFORMACION:

☐ Continuar con el Cuidado Médico
☐ Pago de la Reivindicación
☐ Escuela
☐ Compensación al Trabajador
☐ Legal
☐ Para Uso Personal

Se dará toda información sobre alcohol y / o abuso de drogas **a menos** que usted escribe sus iniciales abajo:

☐ Otro (especifique): __Sport Physical_____

INFORMATION QUE SE ENTREGARA: Entre las siguientes fechas. De: 4/30/2025

☐ Resumen de Alta
☐ Examen H&P
☐ Consulta
☐ Notas sobre el progreso/ médicos
☐ Ordenes
☐ Otros(especifique el contenido y las fechas):
☐ Informes de Rayos X
☐ Rayos X
☐ Pruebas de Diagnóstico
☐ Informes de Procedimiento
☐ Informes de Laboratorio/patología
☐ Pruebas del HIV/AIDS

YO RECONOZCO QUE COMPRENDO:

- Entiendo que la fecha de vencimiento de esta autorización es de un año desde la fecha de hoy.
- Entiendo que puedo revocar esta autorización en cualquier momento, por escrito.
- Entiendo que la información usada o divulgada de acuerdo con esta autorización puede estar sujeta a una nueva divulgación hecha por el recipiente y no está protegida por las regulaciones federales.

Firma del Paciente _____ Fecha

Firma de la Persona Autorizada _____ Parents con el Paciente

Original: 04/01/15 Approved: 04/29/15

MIDDLE PARK HEALTH
Keeping Life Grand

NAME OF STUDENT ATHLETE:

_____

SPORTS THERAPY AND/OR ATHLETIC TRAINING CONSENT

1. **CONSENT FOR SPORTS THERAPY AND/OR ATHLETIC TRAINING SERVICES. I voluntarily consent to and authorize the rendering of Sports Therapy and/or Athletic Training services, including but not limited to advice about seeking x-rays, imaging, or other diagnostic techniques. I also authorize the Sports Therapy and/or Athletic Training staff to evaluate any injury or illnesses that may occur during my participation. My sports therapist and/or athletic trainer will discuss with me the risks, benefits, and alternatives to the recommended treatments. I understand that Sports Therapy and/or Athletic Training services may be rendered by students, interns or residents under supervision. I further understand that this practice is not an exact science and I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in this or by Kremmling Memorial Hospital District dba Middle Park Health (MPH).**

   _____ (Initial) I understand that copies of my medical records may be sent to or shared with other practitioners, providers, healthcare facilities, as permitted by law. I understand that my rights and responsibilities with regard to my care are described in more detail on the Patient Bill of Rights document. I understand that it is my responsibility to inform the Sports Therapy and/or Athletic Training staff if a change in my health occurs or I sustain an injury during my participation. I agree to engage in treatment guidelines as well as management including rehabilitation processes and understand I will not be released to return to participation until those guidelines are reached.

   _____ (Initial) I consent to allow the Sports Therapy and/or Athletic Training Staff to share medical information with appropriate high school administration and coaching staff for any injury or illness evaluated by a Sports Therapy and/or Athletic training staff member

2. **COMMUNICATIONS CONSENT. By providing my cell or other phone number(s), I expressly consent to receive communications from MPH, its agents or business associates at any numbers I provide or that are later acquired, to be used to contact me by live agent, voice mail, text message, using an auto dialer or other computer- assisted technology, pre-recorded message, or by any other form of electronic communication for any purpose, including scheduling, notifications, confirmations, reminders, instructions, accounting, billing, assignment of benefits, and/or collections. I understand that depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new numbers if my numbers change. Providing these numbers is not a condition of receiving Sports Therapy and/or Athletic Training services.**

3. **PERSONAL VALUABLES. I understand that MPH does not assume responsibility for the loss, damage, or disposal of my personal property or money including jewelry, clothing, dentures, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other item unless such money or property is deposited with MPH. I take full responsibility for any money or property retained in my possession/room or brought to me while I am a patient of MPH.**

MIDDLE PARK HEALTH
Keeping Life Grand

NAME OF STUDENT ATHLETE:

_____

4. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES. I acknowledge that MPH has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on the MPH web-site. I understand this acknowledgement in no way affects the care I receive at MPH.

By checking one of the boxes below, I acknowledge:

☐ **I accepted a copy of the Notice of Privacy Practices**

☐ **I declined a copy of the Notice of Privacy Practices**

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____ _____

SIGNATURE OF PARENT OR LEGAL RESPONSIBLE PERSON

PRINT NAME

_____ _____

RELATIONSHIP/REASON WHY PATIENT IS UNABLE TO SIGN

EMERGENCY CONTACNT PHONE #

_____

EMERGENGY CONTACT EMAIL ADDRESS

DATE _____

PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.

This form is valid for 365 calendar days from the date signed below.

1

Revised 8/24

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Gender: _____ Age: _____ Date of Birth: ___/___/_____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

List past and current medical conditions:

_____

Have you ever had surgery? If yes, please list all surgical procedures and dates:

_____

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

_____

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

_____

Patient Health Questionnaire version 4 (PHQ-4)

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

	Not at all	Several days	Over half of the days	Nearly everyday
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

	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 illnesses?		
	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?		

	HEART HEALTH QUESTIONS ABOUT YOU *(continued)*	**Yes**	**No**
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
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? (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), Bragada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.

This form is valid for 365 calendar days from the date signed below.

2

Revised 8/24

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

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

MEDICAL QUESTIONS *(continued)*		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports- related injuries and death. CHSAA bylaw 1780.1 states, "No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until there is a statement on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that: (a) he/she/they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics; and (c) that he/she/they has the consent of his/her/ their parents or legal guardian to participate. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until this form is completed in its entirety and page 4 is on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that: (a) he/she/ they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics. The CHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____*(printed)* Student-Athlete Signature: _____ Date: ___/ ___/ ___

Parent/Guardian Name: _____*(printed)* Parent/Guardian Signature: _____ Date: ___/ ___/ ___

Parent/Guardian Name: _____*(printed)* Parent/Guardian Signature: _____ Date: ___/ ___/ ___

This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.

This form is valid for 365 calendar days from the date signed below.

3

Revised 8/24

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

PHYSICIAN REMINDERS:

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?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	
• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?	

☐ Verify completion of Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION			
Height:	**Weight:**		
BP: / (/)	**Pulse:**	**Vision:** R 20/ L 20/	**Corrected:** Yes No

MEDICAL - healthcare professional shall initial each assessment	**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 • 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 - healthcare professional shall initial each assessment	**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		

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/ ___/ _____

Address: _____ Phone: (____) _____ E-mail: _____

PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT ONLY THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

4

Revised 8/24

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Gender: _____ Age: _____ Date of Birth: ___/___/_____
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (_____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

_____

I hereby certify that I have examined the above-named student-athlete using the CHSAA Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/___/_____

Address: _____ Phone: (_____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

List any medical history that is relevant to participation in competitive sports. *(explain below, use additional sheet, if necessary)*

_____

_____

_____

☐ Allergies/Anaphylaxis ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait
☐ Mental Health ☐ N/A – No relevant medical information to disclose

Medications: *(use additional sheet, if necessary)*

List: _____

_____

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct.

This form is not considered valid unless all sections are complete.

EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN (Página 1 de 4)

Este formulario de historia clínica debe ser conservado por el proveedor de atención médica y/o los padres y no convertido en la escuel .

El documento tiene una validez de 365 días a partir de la fecha de firma que se indica a continuación.

1

Revisado 8/24

FORMULARIO DE HISTORIA CLÍNICA

Información de Estudiante (a ser completada por el estudiante y los padres) *en letra de imprenta legible*

Nombre completo del estudiante: _____ Género: _____ Edad: _____
Fecha de nacimiento: _____/_____ /_____ Escuela: _____ Grado en la escuela: Deporte(s): _____
Domicilio: _____ Ciudad/Estado: _____ Numero de teléfono: (_) _____
Nombre del Padre/Tutor: _____ Correo electrónico: _____
Persona de contacto en caso de emergencia: _____ Relación con el estudiante: _____
Teléfono celular de contacto de emergencia: (_____) ____ Teléfono del trabajo: (_____) _____Otro teléfono: (____) _____
Proveedor de atención médica familiar: _____ Ciudad/Estado: _____ Teléfono de la oficina: (_____) _____

Enumere las condiciones médicas pasadas y actuales:

_____

¿Alguna vez te has sometido a una cirugía? En caso afirmativo, enumere todos los procedimientos quirúrgicos y las fechas:

_____

Medicamentos y suplementos (enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (a base de hierbas y nutricionales) actuales):

_____

¿Tienes alguna alergia? En caso afirmativo, enumere todas sus alergias (es decir, medicamentos, polen, alimentos, insectos):

_____

Cuestionario de Salud del Paciente versión 4 (PHQ-4)

En las últimas dos semanas, ¿con qué frecuencia le ha molestado alguno de los siguientes problemas? (Respuesta en círculo)

	No del todo	Varios días	Más de la mitad de los días	Casi todos los días
Sentirse nervioso o ansioso	0	1	2	3
No ser capaz de detener o controlar la preocupación	0	1	2	3
Poco interés o placer en hacer las cosas	0	1	2	3
Sentirse deprimido o desesperanzado	0	1	2	3

	PREGUNTAS GENERALES Explique las respuestas afirmativas al final de este formulario. Encierra en un círculo las preguntas si no sabes la respuesta.	**Sí**	**No**
1	¿Tiene alguna inquietud que le gustaría discutir con su proveedor?		
2	¿Alguna vez un proveedor le ha negado o restringido su participación en deportes por cualquier motivo?		
3	¿Tiene algún problema médico en curso o enfermedad reciente?		
	PREGUNTAS SOBRE SU SALUD CARDÍACA	**Sí**	**No**
4	¿Alguna vez te has desmayado o casi te has desmayado durante o después de ejercicio?		
5	¿Alguna vez ha tenido molestias, dolor, opresión o presión en ¿Tu pecho durante el ejercicio?		
6	¿Alguna vez tu corazón se acelera, revolotea en tu pecho o se salta latidos (latidos irregulares) durante el ejercicio?		
7	¿Alguna vez un médico le ha dicho que tiene algún problema cardíaco?		

	PREGUNTAS SOBRE SU SALUD CARDÍACA *(continuación)*	**Sí**	**No**
8	¿Alguna vez un médico ha solicitado una prueba para su corazón? Por ejemplo, electrocardiografía (ECG) o ecocardiografía (ECHO)?		
9	¿Te sientes mareado o te falta el aire que tus amigos durante el ejercicio?		
10	¿Alguna vez has tenido una convulsión?		
	PREGUNTAS SOBRE LA SALUD CARDÍACA DE SU FAMILIA	**Sí**	**No**
11	¿Algún miembro de la familia o pariente ha muerto de problemas cardíacos o ha tenido una muerte súbita inesperada o inexplicable antes de los 35 años? (incluyendo ahogamiento o accidente automovilístico inexplicable)		
12	¿Alguien en tu familia tiene un problema cardíaco genético, como miocardiopatía hipertrófica (MCH), síndrome de Marfan, miocardiopatía arritmogénica del ventrículo derecho (MAVD), síndrome de QT largo (SQTL), síndrome de QT corto (SQTS), síndrome de Brugada o taquicardia ventricular polimórfica catecolaminérgica (CPVT)?		
13	¿Alguien en su familia ha tenido un marcapasos o un implante? ¿Desfibrilador antes de los 35 años?		

Este formulario de historia clínica debe ser conservado por el proveedor de atención médica y/o los padres y no convertido en la escuel .

El documento tiene una validez de 365 días a partir de la fecha de firma que se indica a continuación.

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Nombre completo del estudiante: _____ Fecha de nacimiento: / / Escuela: _____

	PREGUNTAS SOBRE HUESOS Y ARTICULACIONES	Sí	No
14	¿Alguna vez has tenido una fractura por estrés?		
15	¿Alguna vez se lesionó un hueso, músculo, ligamento, articulación o tendón?¿Qué te hizo perderte una práctica o un partido?		
16	¿Tiene una lesión en los huesos, músculos, ligamentos o articulaciones que actualmente le molesta?		
	PREGUNTAS MÉDICAS	**Sí**	**No**
17	¿Tose, tiene sibilancias o dificultad para respirar durante o después del ejercicio, o alguna vez un proveedor le ha diagnosticado asma?		
18	¿Le falta un riñón, un ojo, un testículo, el bazo o cualquier otro otro órgano?		
19	¿Tiene dolor en la ingle o los testículos, o una protuberancia o hernia dolorosa? ¿En la zona de la ingle?		
20	¿Tienes erupciones cutáneas recurrentes o erupciones cutáneas que aparecen y desaparecen, como herpes o Staphylococcus aureus resistente a la meticilina (SARM)?		
21	¿Ha tenido una conmoción cerebral o una lesión en la cabeza que le causó confusión, dolor de cabeza prolongado o problemas de memoria?		
22	¿Alguna vez ha tenido entumecimiento, hormigueo, debilidad en los brazos o las piernas, o no ha podido mover los brazos o las piernas después de recibir un golpe o una caída?		
23	¿Alguna vez te has enfermado mientras hacías ejercicio en el calor?		
24	¿Usted o alguien de su familia tiene el rasgo o la enfermedad de células falciformes?		
25	¿Alguna vez has tenido o tienes algún problema con los ojos o la visión?		

	PREGUNTAS MÉDICAS *(continuación)*	Sí	No
26	¿Te preocupa tu peso?		
27	¿Está tratando o alguien le ha recomendado que aumente o pierda peso?		
28	¿Sigues una dieta especial o evitas ciertos tipos de alimentos o grupos de alimentos?		
29	¿Alguna vez has tenido un trastorno alimentario?		

Explique las respuestas afirmativas aquí:

_____

_____

_____

_____

_____

_____

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_____

La participación en deportes en la escuela secundaria no está exenta de riesgos. El estudiante-atleta y el padre/tutor reconocen que las respuestas veraces a las preguntas anteriores permiten que un médico capacitado evalúe al estudiante-atleta individual contra los factores de riesgo asociados con las lesiones y la muerte relacionadas con el deporte. El estatuto 1780.1 de CHSAA establece: "Ningún alumno participará en la práctica formal o representará a su escuela en atletismo interescolar hasta que haya una declaración en el archivo con el director o director atlético firmada por sus padres o tutor legal y un practicante con licencia en los Estados Unidos para realizar exámenes físicos deportivos que certifique que: (a) ha pasado un examen físico adecuado en los últimos 365 días calendario; (b) que, en opinión del practicante con licencia examinador, él/ella/ellos están físicamente aptos para participar en el atletismo de la escuela secundaria; y (c) que tiene el consentimiento de sus padres o tutor legal para participar. Esta evaluación física previa a la participación se completará cada año antes de participar en una competencia atlética interescolar o participar en cualquier práctica, prueba, entrenamiento, acondicionamiento u otra actividad física, incluidas las actividades que ocurren fuera del año escolar.

Por la presente declaramos, a nuestro leal saber y entender, que nuestras respuestas a las preguntas anteriores son completas y correctas. Ningún alumno participará en la práctica formal o representará a su escuela en atletismo interescolar hasta que este formulario se complete en su totalidad y la página 4 esté archivada con el director o director atlético firmada por sus padres o tutor legal y un profesional con licencia en los Estados Unidos para realizar exámenes físicos deportivos que certifique que: (a) ha pasado un examen físico adecuado dentro de los últimos 365 días calendario; (b) que, en opinión del practicante con licencia examinador, él/ella/ellos están físicamente aptos para participar en el atletismo de la escuela secundaria. El Comité Asesor de Medicina Deportiva de CHSAA recomienda encarecidamente una evaluación médica con su proveedor de atención médica para detectar factores de riesgo de paro cardíaco repentino, que pueden incluir las pruebas especiales enumeradas anteriormente.

Nombre del estudiante-atleta: _____*(impreso)* Firma del estudiante-atleta: _____ Fecha:___/____/____

Nombre del Padre/Tutor: _____*(impreso)* Firma del Padre/Tutor: _____ Fecha: ___/ ___/ ___

Nombre del Padre/Tutor: _____*(impreso)* Firma del Padre/Tutor: _____ Fecha: ___/ ___/ ___

Este formulario de historia clínica debe ser conservado por el proveedor de atención médica y/o los padres y no convertido en la escuel .

El documento tiene una validez de 365 días a partir de la fecha de firma que se indica a continuación.

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FORMULARIO DE EXAMEN FÍSICO

Nombre completo del estudiante: _____ Fecha de nacimiento: ___/___/____Escuela: _____

RECORDATORIOS PARA MÉDICOS:

Considere preguntas adicionales sobre temas más delicados.

• ¿Te sientes estresado o bajo mucha presión?	• ¿Alguna vez te has sentido triste, desesperanzado, deprimido o ansioso?
• ¿Te sientes seguro en tu casa o residencia?	• Durante los últimos 30 días, ¿consumió tabaco de mascar, rapé o salsa?
• ¿Alguna vez has tomado algún suplemento que te ayude a ganar o perder peso o mejorar tu rendimiento?	
• ¿Alguna vez has tomado esteroides anabólicos o usado algún otro suplemento para mejorar el rendimiento?	

☐ Verifique la finalización de la historia clínica (páginas 1 y 2), revise estas respuestas de la historia clínica como parte de su evaluación. Las preguntas sobre la historia cardiovascular/síntomas incluyen la pregunta 4 a la pregunta 13 del formulario de historia clínica. *(marque la casilla si está completa)*

EXAMEN			
Altura:	**Peso:**		
BP: / (/)	**Pulso:**	**Visión:** R 20/ L 20/	**Corregido:** Sí No

MÉDICO: el profesional de la salud debe poner sus iniciales en cada evaluación	**NORMAL**	**HALLAZGOS ANORMALES**
Apariencia • Estigmas de Marfan (cifoescoliosis, paladar arqueado alto, tórax en embudo, aracnodáctilo, hiperlaxitud, miopía, prolapso de la válvula mitral [PVM] e insuficiencia aórtica)		
Ojos, oídos, nariz y garganta • Pupilas de los ojos iguales • Oído		
Ganglios linfáticos		
Corazón • Soplos (auscultación de pie, auscultación supina y maniobra de Valsalva)		
Pulmones		
Abdomen		
Piel • Virus del herpes simple (VHS), lesiones sugestivas de Staphylococcus aureus resistente a la meticilina (SARM) o tiña del cuerpo		
Neurológico		

MUSCULOESQUELÉTICO - profesional de la salud deberá poner sus iniciales en cada evaluación	**NORMAL**	**HALLAZGOS ANORMALES**
Cuello		
Espalda		
Hombro y brazo		
Codo y antebrazo		
Muñeca, mano y dedos		
Cadera y muslo		
Rodilla		
Pierna y tobillo		
Pie y dedos de los pies		
Funcional • Prueba de sentadilla con dos piernas, prueba de sentadilla con una sola pierna y prueba de caída de caja o caída de paso		

Nombre del profesional de la salud (en letra de imprenta o mecanografiado): _____Fecha del examen:___/___/___

Dirección: _____Teléfono: ( ) _____Correo electrónico: _____

EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN (Página 4 de 4)

ENVÍE SOLO ESTE FORMULARIO DE ELEGIBILIDAD MÉDICA A LA ESCUELA

El documento tiene una validez de 365 días a partir de la fecha de firma que se indica a continuación.

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FORMULARIO DE ELEGIBILIDAD MÉDICA

Información del estudiante (debe ser completada por el estudiante y los padres) *impresa de manera legible*

Nombre completo del estudiante: _____ Género : _____ Edad: _____
Fecha de nacimiento: ____ /____ /_____ Escuela: _____ Grado en la escuela: _____ Deporte(s): _____
Domicilio: _____ Ciudad/Estado: _____ Teléfono de casa: (__) _____
Nombre del Padre/Tutor: _____ Correo electrónico: _____
Persona de contacto en caso de emergencia: _____ Relación con el estudiante: _____
Teléfono celular de contacto de emergencia: (_____) ____ Teléfono del trabajo: (_____) _____Otro teléfono: (____) _____
Proveedor de atención médica familiar: _____ Ciudad/Estado: _____ Teléfono de la oficina: (_____) _____

☐ Médicamente elegible para todos los deportes sin restricciones

☐ Médicamente elegible para todos los deportes sin restricción con recomendaciones para una evaluación o tratamiento adicional de: *(use una hoja adicional, si es necesario)*

☐ Médicamente elegible solo para ciertos deportes como se enumeran a continuación:

_____

☐ No es médicamente elegible para ningún deporte

_____

Recomendaciones: *(utilizar hoja adicional, si es necesario)*

Por la presente certifico que he examinado al estudiante-atleta mencionado anteriormente utilizando la Evaluación Física de Preparticipación de CHSAA y he proporcionado la(s) conclusión(es) enumerada(s) anteriormente. Se ha conservado una copia del examen y los padres pueden acceder a él si lo solicitan. Cualquier lesión u otra afección médica que surja después de la fecha de esta autorización médica debe ser evaluada, diagnosticada y tratada adecuadamente por un profesional de la salud adecuado antes de participar en las actividades.

Nombre del profesional de la salud (en letra de imprenta o mecanografiado): _____Fecha del examen: / / _____

Dirección: _____Teléfono: ( ) _____

Firma del Profesional de la Salud: _____Credenciales: _____Licencia #: _____

INFORMACIÓN DE EMERGENCIA COMPARTIDA: completada en el momento de la evaluación por el profesional y los padres.

Anote cualquier historial médico que sea relevante para la participación en deportes competitivos. *(explique a continuación, use una hoja adicional, si es necesario)*

_____

_____

_____

☐ Alergias/Anafilaxia ☐ Asma ☐ Cardíaco/Corazón ☐ Conmoción cerebral ☐ Diabetes ☐ Enfermedad por calor Historial ☐ quirúrgico ortopédico ☐ rasgo ☐ de células falciformes ☐ Salud mental ☐ N/A – No hay información médica relevante para divulgar

Medicamentos: *(use una hoja adicional, si es necesario)*

Explicar:_____

_____

Firma del alumno: _____Fecha: __/___/____ Firma del Padre/Tutor:_____ Fecha: __/___/____

Por la presente declaramos, a nuestro leal saber y entender, que la información registrada en este formulario es completa y correcta.

Este formulario no se considera válido a menos que todas las secciones estén completas.