



April 11<sup>th</sup>, 2012

Dear Parent,

We are frequently asked to provide a medical evaluation and complete forms required by a school district, organization or club to clear a child for participation in certain physical activities.

These "sports physicals" should not replace the annual well-child exam. The annual well-child exam allows us to discuss any health problems your child may have, including acne or chronic health conditions. It is also our opportunity to discuss with your child any important topics such as peer pressure, nutrition, avoiding drugs, wearing seatbelts, etc. We want to develop an open, trusting relationship with you and your child so you can turn to us with questions regarding puberty, normal development or any medical condition.

If your child has had a well-child exam within the last year and now needs a sports physical, we may need to update the medical history and provide a limited exam prior to completing the clearance form. We charge \$20.00 for this service, which is payable by check or cash at the time of your visit, as insurance companies may not cover this service.

If it has been more than a year since your child's last well-child exam, we recommend that you schedule a well-child exam rather than a sports physical. Most Insurance companies will cover this as a "preventative exam" and should be of minimal charge to you. We will then complete the clearance form at the same time.

We have included some guidelines of explanation of "Kindergarten", "7<sup>th</sup> Grade" and "College" physicals. These physicals will be billed at our "well-child preventative rate" and submitted to your insurance.

If you would like to schedule a physical for your child, please call SMC at (402) 443-4191. Sports physicals can be scheduled M-F 8am-5pm. If you will not be with your child at the appointment, please have the Sports Consent Form, Preparticipation Physical Evaluation Form completed, and money with your child at time of appointment. If your child does not use our facility for their primary care, additional paperwork from the facility will be required. All forms must be completed before child can be seen.

Thank you for choosing SMC to provide this important service. We value your trust and welcome your comments or questions. You may also schedule your child at Ashland Family Clinic (402) 944-2201.

Sincerely,

A handwritten signature in cursive script that reads "Lori Russell".

Lori Russell, RN (clinic supervisor)



Kindergarten Physical Includes:

- \* Review of your Health History
- \* Health Physical by your provider
- \* Immunizations are updated
- \* Vision exam performed
- \* Labs to include: UA

7<sup>th</sup> Grade Physical Includes:

- \* Review of your Health History
- \* Health Physical by your provider
- \* Immunizations are updated...Required to Receive 1 dose of Tdap (must contain Pertussis booster)

College Physical Includes:

- \* Review of your Health History
- \* Health Physical by your provider
- \* Any other requirements by the college

# Preparticipation Physical Evaluation

**HISTORY  
FORM**

DATE OF EXAM \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Personal physician \_\_\_\_\_  
**In case of emergency, contact**  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

**Explain "Yes" answers below.  
 Circle questions you don't know the answers to.**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply):<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection |                          |                          |
| 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:   | <input type="checkbox"/> | <input type="checkbox"/> |

|            |            |          |           |       |           |              |           |
|------------|------------|----------|-----------|-------|-----------|--------------|-----------|
| Head       | Neck       | Shoulder | Upper arm | Elbow | Forearm   | Hand/fingers | Chest     |
| Upper back | Lower back | Hip      | Thigh     | Knee  | Calf/shin | Ankle        | Foot/toes |

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 20. Have you ever had a stress fracture?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has a doctor ever told you that you have asthma or allergies?                                  | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have headaches with exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you happy with your weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor?                                 | <input type="checkbox"/> | <input type="checkbox"/> |

**FEMALES ONLY**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 47. Have you ever had a menstrual period?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How old were you when you had your first menstrual period? | _____                    |                          |
| 49. How many periods have you had in the last year?            | _____                    |                          |

Explain "Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

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**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

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Not cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY INFORMATION**

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

**IMMUNIZATIONS** (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

Up to date (see attached documentation)  Not up to date Specify \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone 402-443-4141

Signature of physician \_\_\_\_\_, MD or DO

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Saunders Medical Center  
1760 County Rd J  
Wahoo, NE 68066

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

### Follow-Up Questions on More Sensitive Issues

|   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Do you feel stressed out or under a lot of pressure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel safe?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 30 days, did you use chewing tobacco, snuff, or dip?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 30 days, have you had at least 1 drink of alcohol?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever taken steroid pills or shots without a doctor's prescription?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Questions from the Youth Risk Behavior Survey ( <a href="http://www.cdc.gov/HealthyYouth/yrbs/index.htm">http://www.cdc.gov/HealthyYouth/yrbs/index.htm</a> ) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc | <input type="checkbox"/> | <input type="checkbox"/> |

Notes:

|                        | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|------------------------|--------|-------------------|-----------|
| <b>MEDICAL</b>         |        |                   |           |
| Appearance             |        |                   |           |
| Eyes/ears/nose/throat  |        |                   |           |
| Hearing                |        |                   |           |
| Lymph nodes            |        |                   |           |
| Heart                  |        |                   |           |
| Murmurs                |        |                   |           |
| Pulses                 |        |                   |           |
| Lungs                  |        |                   |           |
| Abdomen                |        |                   |           |
| Genitourinary†         |        |                   |           |
| Skin                   |        |                   |           |
| <b>MUSCULOSKELETAL</b> |        |                   |           |
| Neck                   |        |                   |           |
| Back                   |        |                   |           |
| Shoulder/arm           |        |                   |           |
| Elbow/forearm          |        |                   |           |
| Wrist/hand/fingers     |        |                   |           |
| Hip/thigh              |        |                   |           |
| Knee                   |        |                   |           |
| Leg/ankle              |        |                   |           |
| Foot/toes              |        |                   |           |

\*Multiple-examiner set-up only.

†Having a third party present is recommended for the genitourinary examination.

Notes:

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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1760 COUNTY ROAD J WAHOO, NE 68066

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### SPORTS PHYSICAL CONSENT FORM

Student Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Phone Number \_\_\_\_\_ School \_\_\_\_\_

The above student has my consent to receive a sports physical, as required by his/her school, from Saunders Medical Center.



Our HIPAA Notice of Privacy Practices is available on our web site at [www.saundersmedicalcenter.com](http://www.saundersmedicalcenter.com); it is also available at the Saunders Medical Center Clinic. If you would like a copy, please check the box below and a notice will be mailed to you. Your signature confirms that you have been given an opportunity to review our Notice of Privacy Practices.

Yes, Please mail the Notice of Privacy Practices to the above address.

Parent or Guardian of Student (Please Print) \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_