WYOMING HIGH SCHOOL ACTIVITIES ASSOCIATION

SCHOOL PHYSICAL EXAMINATION

MEDICAL RECORD

PHYSICIANS STATEMENT MUST BE DATED AFTER MAY 1 TO BE VALID FOR THE UPCOMING SCHOOL YEAR

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. Have you had a medical illness or injury since your last check up or sports physical?	[ ]	[ ]
2. Have you ever been hospitalized overnight?	[ ]	[ ]
3. Are you currently taking any prescription of nonprescription (over-the-counter) medications or pills or using an inhaler?	[ ]	[ ]
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	[ ]	[ ]
5. Have you ever passed out during or after exercise?	[ ]	[ ]
Have you ever been dizzy during or after exercise?	[ ]	[ ]
Have you ever had chest pain during or after exercise?	[ ]	[ ]
Do you get tired more quickly than your friends do during exercise?	[ ]	[ ]
Have you ever had racing of your heart or skipped heartbeats?	[ ]	[ ]
Have you had high blood pressure or high cholesterol?	[ ]	[ ]
Have you ever been told you have a heart murmur?	[ ]	[ ]
Has any family member or relative died of heart problems or of sudden death before age 50?	[ ]	[ ]
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	[ ]	[ ]
Has a physician ever denied or restricted your participation in sports for any heart problems?	[ ]	[ ]
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	[ ]	[ ]
7. Have you ever had a head injury or concussion?	[ ]	[ ]
Have you ever been knocked out, become unconscious, or lost your memory?	[ ]	[ ]
Have you ever had a seizure?	[ ]	[ ]
Do you have frequent or severe headaches?	[ ]	[ ]
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	[ ]	[ ]
Have you ever had a stinger, burner, or pinched nerve?	[ ]	[ ]
8. Have you ever become ill from exercising in the heat?	[ ]	[ ]
9. Do you cough, wheeze, or have trouble breathing during or after activity?	[ ]	[ ]
Do you have asthma?	[ ]	[ ]
Do you have seasonal allergies that require medical treatment?	[ ]	[ ]

	Yes	No
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	[ ]	[ ]
11. Have you had any problems with your eyes or vision?	[ ]	[ ]
Do you wear glasses, contacts, or protective eyewear?	[ ]	[ ]
12. Have you ever had a sprain, strain, or swelling after injury?	[ ]	[ ]
Have you broken or fractured any bones or dislocated any joints?	[ ]	[ ]
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	[ ]	[ ]

If yes, check appropriate box and explain below

[ ] Head	[ ] Elbow	[ ] Hip
[ ] Neck	[ ] Forearm	[ ] Thigh
[ ] Back	[ ] Wrist	[ ] Knee
[ ] Chest	[ ] Hand	[ ] Shin/calf
[ ] Shoulder	[ ] Finger	[ ] Ankle
[ ] Upper Arm		[ ] Foot

13. Do you want to weigh more or less than you do now?	[ ]	[ ]
Do you lose weight regularly to meet weight requirements for your sport?	[ ]	[ ]
14. Do you feel stressed out?	[ ]	[ ]
15. Do you, or someone in your family, have sickle cell trait or disease?	[ ]	[ ]

FEMALES ONLY

16. When was your first menstrual period? _____`

When was your most recent menstrual period? _____`

How much time do you usually have from the start of one period to the start of another? _____`

How many periods have you had in the last year? _____`

What was the longest time between periods 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 _____`

PARENT/GUARDIAN CONSENT FOR EMERGENCY MEDICAL ASSISTANCE

I hereby authorize _____ School District and its faculty members in charge of my child named below to obtain all necessary medical care for my child in the event that I cannot be reached to authorize it myself. I hereby authorize any licensed physician and/or medical personnel to render necessary medical treatment to my child.

Student's Name _____ Work Phone Number; Father _____

Address _____ Mother _____

_____ Home Phone Number _____

INSURANCE INFORMATION: Company _____ Policy # _____

Insured Person _____

Policy Holder's Social Security Number _____

Signature acknowledges that we have read and understand the above warning and we give consent for emergency assistance that might be needed.

Date _____ Signature of Parent/Guardian _____

WYOMING HIGH SCHOOL ACTIVITIES ASSOCIATION
SCHOOL PHYSICAL EXAMINATION
MEDICAL RECORD

PHYSICIANS STATEMENT MUST BE DATED AFTER MAY 1 TO BE VALID FOR THE UPCOMING SCHOOL YEAR

DATE OF EXAM _____

Name _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ____/____ (____/____, ____/____)

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

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

*Normal indicated by check or N

[ ] **Cleared**

*[ ] **Cleared after completing evaluation/rehabilitation for:** _____

_____

_____

_____

*[ ] **Not cleared for:** _____ **Reason:** _____

Recommendations: _____

_____

_____

***IF THESE BOXES ARE CHECKED, A COPY OF THIS FORM NEEDS TO BE SENT TO THE APPROPRIATE SCHOOL DISTRICT.**

Name of physician (print/type) _____ **Date** _____

Address _____ **Phone** _____

Signature of physician _____, **MD or DO**

STUDENT/PARENT/GUARDIAN INFORMED CONSENT

Participation in all activities requires the acceptance of risk of possible serious injury. The risk can be minimized by following your coaches' rules and procedures, by familiarizing yourself with the rules of the activity, and by following the specific rules issued by manufacturers for the safe use of your activity equipment. The risk is always there, but you can help minimize it by making safety a shared responsibility. When you make the decision to participate in an activity, you are assuming the shared responsibility of following the activities rules, the coaches' rules, and the equipment manufacturer's rules. You, as a participant, can help make the activity safer by not intentionally using techniques which are illegal and which can cause serious injury.

Your signature below indicates that you have been informed about the importance of following rules in activities participation; and you realize that there is a risk of being injured that is inherent in all activities. You realize that the risk of injury may be severe, including the risk of fractures, brain injuries, paralysis or even death.

Activity programs specifically excluded: _____

Date _____ Signature of Student _____

Signature of Parent _____

Kimball Health Services
CARING...close to home

Pine Bluffs Health Clinic
117 E 4th St.
(307) 245-3666

Patient Information

Date: _____

Patient Name: _____ Birthdate: _____

Patient Mailing Address: _____

Patient Physical Address: _____

Home Phone: _____Work Phone: _____

Cell Phone: _____ Email: _____
(Email is for internal use only)

(Circle one) Married Single Divorced Separated

Sex: (Circle one) Male Female

Responsible Party or Spouse _____Relationship_____

Employer: _____

Employer Address: _____

Notify in Case of Emergency: _____

Address: _____Phone: _____

Do you smoke tobacco? _____No _____Yes _____Years

Do you chew tobacco? _____No _____Yes _____Years

How did you hear about us? _____

Kimball Health Services
CARING...close to home

Pine Bluffs Health Clinic
117 E 4th St.
(307) 245-3666

AUTHORIZATION AND TREATMENT CONSENT

PATIENT NAME: _____

BIRTHDATE: _____ SS# _____

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to the Kimball Health Services Clinic for any services furnished to me by that clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA - 1500 form, or elsewhere on other approved forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

CONSENT: I, (or _____ for _____) do hereby voluntarily consent to such diagnostic procedures, hospital care and medical, surgical, treatment by Kimball Health Services Clinic physician(s), physician assistants, nurse practitioners, or physician's designees as is necessary in his/her judgment. I acknowledge that no guarantees have been made to me as the result of treatments or examination in this facility.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize and request payment directly to Kimball Health Services Clinic of any surgical and/or medical benefits due me under the terms of my insurance policy for services rendered.`

SIGNED: _____ DATE: _____

Kimball Health Services
CARING...close to home

Pine Bluffs Health Clinic
117 E 4th St.
(307) 245-3666

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you read and sign prior to treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD.

Time of Service Fees

For non-covered patients, a payment of $50.00 payment will be collected at time of service and applied to the office call fee. If you have insurances with deductible plans, the following will apply:

- If you have not met your deductible, the clinic will charge $50 towards the office call fee.
- If you have met your deductible, you will be informed that there will not be a copay.
- If you have a copay listed on your card or in the eligibility; the office copay will be due at time of service.

Regarding Insurance

The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a third party to that contract.

We will be happy to assist you in making payment arrangements at time of service. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or the other medical insurance.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____
PRINT PATIENT NAME

X _____ **DATE**

_____
Signature of Patient/Responsible Party/Personal Representative

X _____
Relationship to Patient if signed by Responsible Party/Personal Representative

106.0.0.22c

Kimball Health Services
Patient Acknowledgement of Privacy Notice

Patient Name: _____
(Last) (First) (Middle)

Medical Record#: _____ Medical Record #: _____
Clinic Hospital

I have received the Kimball Health Services Notice of Privacy Practices.

_____ _____
Signature of Patient/Personal Representative Date

_____ _____
Relationship to patient if signed by personal representative Date

Documentation of Good Faith Effort
Give a reason if signed acknowledgement is not obtained: ☐ Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient/parent/legal guardian declined to acknowledge the receipt of the Notice of Privacy Practices. ☐ Patient/Parent/Legal Guardian stated they had already received the Privacy Notice at another Kimball Health Services location. ☐ Patient/Parent/ Legal Guardian directed to Kimball Health Services website to view the Notice of Privacy Practices. ☐ The Notice of Privacy Practices was mailed to the Patient/Parent/Legal Guardian. ☐ Other_____ _____ _____ Employee Signature Date