COMPLETE THIS SIDE FOR ATHLETES

OFF-SITE SCHOOL PHYSICAL EXAM CONSENT

CONSENT FOR TREATMENT:
I consent to receive care and services from The Clinic at Pagosa Springs Medical Center (PSMC). Clinic services may include, but are not limited to, examination, routine diagnostic procedures, assessment, medical and mental health treatment and administration of medications. These services will be provided by the Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Behavioral Health staff, and/or assistants of any such providers. I understand that I have the right to discuss proposed procedures or treatments with my provider. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the results of examinations or treatments. I understand that this consent covers all clinic procedures not requiring a specific consent and this consent is valid and remains in effect as long as I am seeking services from The Clinic.

AUTHORIZATION TO RELEASE INFORMATION:
I authorize The Clinic to release my health information, in accordance with all local, state and federal law, to any authorized party for the purposes of treatment, payment and healthcare operations. I authorize the release of medical information to my insurers as necessary for determination of benefits and payment of claims; to healthcare providers involved in my care; to quality and utilization review organizations and to companies and community resources that assist me with my health care needs. I understand that in certain circumstances this authorization may be restricted by notifying The Clinic in writing of such restriction.

HEALTH INFORMATION EXCHANGES:
The Clinic participates in the CORHIO Health Information Exchange and the CommonWell Health Information Exchange (HIE). HIE provides participants with a way to securely and efficiently share a patient's clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. You may choose to opt-out of participation in the CORHIO HIE and/or the CommonWell HIE, or cancel an opt-out choice at any time. Unless you choose to opt out, your clinical information, with the exception of psychotherapy session notes that are separately maintained by the provider, will be shared via the health information exchange. To opt-out or cancel an opt-out, please request the relevant form from the registration staff. It may take up to seven days to process your opt-out request, during that time your information will be available on the exchange.

HEALTHCARE WORKER EXPOSURE/BLOOD TESTING:
In the event that a health care worker is exposed to my blood or body fluids, I consent to blood or other tests that may be required to evaluate the worker's risk of contracting Hepatitis B, Hepatitis C or HIV. There will be no charge for the testing.

ACKNOWLEDGEMENTS:

1. Notice of Privacy Practices ☐ I would like a copy
2. Patients' Rights and Responsibilities ☐ I would like a copy
3. Advance Directives ☐ I would like a copy

I acknowledge that I have read this form and understand its contents. I further acknowledge that I am the patient, or person duly authorized either by the patient or otherwise (The Clinic is not responsible for the consideration of custody arrangements), to sign this agreement, consent to and accept its terms.

Print Patient Name: ______________________ **Patient Date of Birth:** ____________

Print Parent/Legal Guardian's Name: ______________________ **Date of Birth:** ____________

Parent/Legal Guardian's Signature: ______________________ **Date:** ________ **Time:** __________

Witness______________________ Date ______________ Time ______________AM/PM

Reviewed/Revised 4/27/2023

This copy will expire in 24 hours

COMPLETE THIS SIDE FOR ATHLETES

PATIENT DEMOGRAPHICS
OFF-SITE SCHOOL PHYSICAL EXAM

Patient's Name: ______________________________ **Date of Birth:** ____ / ____ / _____
First Middle Last

Birth Sex: ☐ Male ☐ Female

Mailing Address: ______________________________
City State Zip Code

Race: ☐ White ☐ Black/African American
☐ American Indian/Alaskan Native
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Unknown ☐ Refuse to Report

Ethnicity: ☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown ☐ Refuse to Report

PARENT/LEGAL GUARDIAN INFORMATION (REQUIRED)

Parent/Legal Guardian's Name: ______________________________
First Middle Last

Date of Birth: ____ / ____ / ____

Mailing Address: ______________________________
City State Zip Code

Home Phone #: (_____) _____ - ________ May we leave a message? ☐ Yes ☐ No
Cell Phone #: (_____) _____ - ________ May we leave a message? ☐ Yes ☐ No
Work Phone #: (_____) _____ - ________

Parent/Legal Guardian's Signature: ______________________________ **Date:** ____/____/______

COMPLETE THIS SIDE FOR ATHLETES

PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

1

Revised 4/24

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?		

COMPLETE THIS SIDE FOR ATHLETES

PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

2

Revised 4/24

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: ___/___/___

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PSMC USE ONLY

PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

3

Revised 4/24

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): PSMC Date of Exam 05/17/2024
Address: 95 S. Pagosa Blvd, Pagosa Springs CO Phone: (970) 731-3700 E-mail: vicki.goeckner@psmedicalcenter.org
Signature of Healthcare Professional: ______________________ Credentials: ____________ License #: ____________

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Student to Complete top Section
Student | Parent sign bottom

PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

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

4

Revised 4/24

MEDICAL ELIGIBILITY FORM

Student

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: (_____) ______

PSMC

☐ 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): PSMC Date of Exam: 5/17 2024
Address: 95 S. Pagosa Blvd Pagosa Springs, CO Phone: (970) 731-3700
Signature of Healthcare Professional: ______ Credentials: ______ License #: ______

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

PSMC

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

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

List: ______

______

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*

☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait ☐ Mental Health

Explain: ______

______

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.

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Optional Heart Screening

Who We Play For (WWPF) is a non-profit organization that provides efficient and non-invasive heart screening to communities nationwide in a mission to eliminate sudden cardiac arrest events in student athletes. With over 7,000 victims each year, Sudden Cardiac Arrest is the leading cause of death amongst student athletes according to the CARES Registry. WWPF will be at the sport's physical event offering these heart screenings to students who have registered free of charge.

About Heart Screenings

Each electrocardiogram (ECG) heart screening is interpreted by a pediatric cardiologist or cardiologist volunteering to serve on WWPF's Medical Advisory Team. These are national and international level experts specifically trained on how to read ECG heart screenings for athletes based on the International Criteria.

Please note, registration ends at 7pm the evening before each screening.

Results are returned via email up to 7 business days after the screening.

How to Sign Up

Go to: https://www.whoweplayfor.org/colorado-archuleta

to register your athlete

Or use the QR Code to register