WHITESIDE COUNTY HEALTH DEPARTMENT

Main Office: 1300 W. 2nd St.
Rock Falls, IL 61071
Phone: 815-626-2230
Fax: 815-626-2231

Environmental Office: 18819 Lincoln Rd.
Morrison, IL 61270
Phone: 815-772-7411
Fax: 815-772-4723

ATTENTION PARENTS/GUARDIANS

Students under 14 years old **MUST** be accompanied by a parent or legal guardian, or with parent/guardian signed consent the child may be accompanied by an adult 18 and older.

ONLY with parent/guardian consent, students 14-17 years old **DO NOT** need to be accompanied by an adult 18 and older.

A treatment consent form **MUST** be signed if a parent/guardian is **NOT** accompanying the student(s) to the school/sports physical.

If a consent form **IS NOT SIGNED** for **EACH** student, that student will not be able to be seen for their scheduled school/sports physical.

NO EXCEPTIONS

***Immunizations will not be available at this event.**

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Consent to Treat a Minor (14 – 17 years of Age)
Without a Parent or Guardian Present

Date: _____

Patient Name:_____

Patient Date of Birth:_____

Name of Parent/Legal Guardian:_____

Telephone Number of Parent/Legal Guardian: _____

I _____ consent for _____ to obtain a school/sports
(Parent/Guardian) (Student)

physical in absence of a parent or guardian.

_____ _____
Signature Date

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Consent to Treat a Minor (14 years of Age and Under)
Without a Parent or Guardian Present

Date: _____

Patient Name:_____

Patient Date of Birth:_____

Name of Parent/Legal Guardian:_____

Telephone Number of Parent/Legal Guardian: _____

I _____ consent for _____ to obtain a school/sports
(Parent/Guardian) (Student)

physical in the presence of _____.
(Must be 18 years or Older)

_____ _____
Signature (Adult Listed Above) Date

_____ _____
Signature (Parent/Guardian) Date

Patient Information (PLEASE PRINT)

PATIENT'S PREFERRED NAME:_____ **Legal Name:**_____

Date of Birth:_____

Pronoun: He She They Other_____

Patient's SSN:_____(photo I.D. required) Phone #:_____

Email:_____

What name would you like to be called in the		
Waiting Room	Preferred	Legal
Exam Room	Preferred	Legal
Phone Calls	Preferred	Legal

Address:_____Apt#:_____City:_____State:_____Zip:_____

Gender Assigned at Birth (circle one): Male/Female

Gender Identity (circle one): Male /Female /Transgender MTF /Transgender FTM/ Decline/Other:_____

Sexual Orientation (circle one): Lesbian/Gay/ Straight/Bi-sexual / Don't Know/ Decline/Other:_____

Ethnicity (circle one): Mexican, Mexican American, or Chicano Puerto Rican Cuban
Another Hispanic, Latino/a, or Spanish Origin Not Hispanic, Latino/a, or Spanish Origin

Race: Asian Indian Chinese Filipino Japanese Korean Vietnamese Native Hawaiian Other Pacific Islander
Guamanian or Chamorro Samoan Black/African American American Indian/Alaska Native White More than one Race

Are you a migrant or seasonal farm worker? Y/N

Are you homeless (e.g. staying with others, in a hotel, in a shelter, living outside, or in a car (Y/N)

Do you require an interpreter? Y/N Are you a U.S. Veteran? Y/N

Emergency Contact Information

Name:_____Relationship:_____Phone #:_____

Guardian/Guarantor information (To be completed by person responsible for this account.)

Person's name responsible for this account(if other than patient listed above):_____

Relationship to patient (circle one): Parent Partner Other:_____

Address:_____City:_____State:_____Zip:_____

Date of birth of person responsible for this account:_____

FINANCIAL AGREEMENT: I hereby assign Whiteside County Community Health Clinic (WCCHC) all my rights, title and interest to reimbursement under any Medicare, Medicaid, or other insurance policies for which benefits may be available for payment of services provided. I sign as an agent, patient, or as "guarantor" that I understand my insurance company will be billed for services I receive at the WCCHC, and that I am directly responsible and agree to pay the WCCHC the balance due of all charges that may not be covered by my insurance. This may include the cost of collection and/or reasonable attorney's fees. I understand that any labs collected by the WCCHC and performed by an outside lab (LabCorp) will be billed separately to my insurance by LabCorp. I give my direct consent and express consent and permission to the clinic or business associates of the clinic to receive account communications, through various means such as 1) any cell, landline, or other phone number that I provide, 2) auto dialer systems, 3) voicemail messages, 4) text messages 5) emergency contact information, 6) pre-recorded forms of voice messaging systems. This information will not be sold.

Name:_____**Signature:**_____**Date:**_____

WHITESIDE COUNTY HEALTH DEPARTMENT & COMMUNITY HEALTH CLINIC
SUMMARY OF NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGEMENT

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS

You have the right to:	• Get a copy of your health and claims record • Correct your health &claims record • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you as your personal representative • File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we may share your information:	• Disclosing information to your family and friends (requires written authorization) • Tell family and friends about your condition • Provide disaster relief • Market our services and sell your information (requires written authorization) • Raise funds • Disclosing return to work notes to your employer • Disclosing return to school notes to your school

OUR USES AND DISCLOSURES

We may use & share your information as we:	• Treat you • Run our organization • Bill for your health services • Help with public health and safety issues such as governmentally declared public health emergencies • Do research • Comply with the law, such as providing proof of immunity to a school • Respond to organ & tissue donation requests and work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions • Provide you with appointment reminders such as voicemail messages, postcards, texts or letters

We will, under most circumstances, not share any health information regarding Behavioral or Mental Health Services, Substance Abuse(drug/alcohol) Treatment, Physical Assault/Abuse/Neglect, and/or Sexually Transmitted Diseases including HIV/AIDS unless specifically requested by a fully executed Authorization to Release Health Care Information.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

I acknowledge that I have been given an opportunity to read this notice and receipt of the notice. I know that I may ask for a copy of the full notice. ***I authorize Whiteside County Health Department/CHC to release school physical records, dental records, to my child's School.***	Authorization to Release Health Care Information _____ Patient (*or Parent/Guardian*) Signature Date

DOCUMENTED VERIFICATION OF INCOME/FAMILY SIZE

Patient Sticker

(Attach copies of proof of income, such as paycheck stubs, income tax returns, etc.)

Always make copies, never hand over originals you may need for use later.

ANNUAL INCOME_____

FAMILY SIZE_____

A PREGNANT WOMAN WILL COUNT AS TWO IN THE FAMILY

SLIDING FEE_____

I certify that the information I have provided is correct, to the best of my knowledge. I understand that I will be held responsible for any consequences (e.g. payments, fines, legal action, etc.) resulting from intentionally providing false or misleading information.	Signature of person responsible for this account Today's Date

WCCHC Sliding Fee Scale 2023. <u>All income categories are from the 2023 Federal Poverty Guidelines</u>

Family Size	Level 1 Slide Medical or BH* $30 Flat Fee Dental Schedule 1 Fees: $35 Schedule 2 Fees: $150	Level 2 Slide Medical or BH* $35 Flat Fee Dental 20% of Full Fee	Level 3 Slide Medical or BH* $50 Flat Fee Dental 40% of Full Fee	Level 4 Slide Medical or BH* $70 Flat Fee Dental 60% of Full Fee	Level 5 Slide Medical or BH* $90 Flat Fee Dental 80% of Full Fee	Level 6 No Discount Full Fee
1	$0 $14,580	$14,581 $18,225	$18,226 $21,870	$21,871 $25,515	$25,516 $29,160	$29,161
2	$0 $19,720	$19,721 $24,650	$24,651 $29,580	$29,581 $34,510	$34,511 $39,440	$39,441
3	$0 $24,860	$24,861 $31,075	$31,076 $37,290	$37,291 $43,505	$43,506 $49,720	$49,721
4	$0 $30,000	$30,001 $37,500	$37,501 $45,000	$45,001 $52,500	$52,501 $60,000	$60,001
5	$0 $35,140	$35,141 $43,925	$43,926 $52,710	$52,711 $61,495	$61,496 $70,280	$70,281
6	$0 $40,280	$40,281 $50,350	$50,351 $60,420	$60,421 $70,490	$70,491 $80,560	$80,561
7	$0 $45,420	$45,421 $56,775	$56,776 $68,130	$68,131 $79,485	$79,486 $90,840	$90,841
8	$0 $50,560	$50,561 $63,200	$63,201 $75,840	$75,841 $88,480	$88,481 $101,120	$101,121
For each additional family member	$5,140	$6,425	$7,710	$8,995	$10,280	
CHC Target Population	Up to and Including 100% of Poverty	To 125% of Poverty	To 150% of Poverty	To 175% of Poverty	Up to and Including 200% of Poverty	Over 200% of Poverty

***The Nominal fee is $30 for Medical and Behavioral Health Services. The Nominal fee is $35 for Schedule 1 Dental services per visit, and the Nominal fee of $150 for Schedule 2 Dental services per visit. Additional Behavioral Health grants and adjustments may apply.**

Interviewer's Signature_____

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CHANGE IN BILLING

I understand my insurance company will be billed for services I receive at Whiteside County Community Health Clinic (WCCHC). In addition, any labs collected by WCCHC and performed by an outside lab (LabCorp) will be billed to my insurance company.

I am aware my insurance may not cover all expenses.

I understand that I am responsible and agree to pay for services not covered by my insurance company.

_____ _____

Signature **Date**

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or **DTaP**						
Tdap; Td or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐**Measles*** ☐**Mumps**** ☐**Rubella** ☐**Varicella** **Attach copy of lab result.**
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes / No	List:	**MEDICATION** (Prescribed or taken on a regular basis.)	Yes / No	List:		
Diagnosis of asthma?	Yes / No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes / No			
Child wakes during night coughing?	Yes / No						
Birth defects?	Yes / No		Hospitalizations? When? What for?	Yes / No			
Developmental delay?	Yes / No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes / No		Surgery? (List all.) When? What for?	Yes / No			
Diabetes?	Yes / No		Serious injury or illness?	Yes / No			
Head injury/Concussion/Passed out?	Yes / No		TB skin test positive (past/present)?	Yes* / No	*If yes, refer to local health department.		
Seizures? What are they like?	Yes / No		TB disease (past or present)?	Yes* / No			
Heart problem/Shortness of breath?	Yes / No		Tobacco use (type, frequency)?	Yes / No			
Heart murmur/High blood pressure?	Yes / No		Alcohol/Drug use?	Yes / No			
Dizziness or chest pain with exercise?	Yes / No		Family history of sudden death before age 50? (Cause?)	Yes / No			
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other				
Ear/Hearing problems?	Yes / No		Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian Signature		Date		
Bone/Joint problem/injury/scoliosis?	Yes / No						

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old | HEIGHT | WEIGHT | BMI | BMI PERCENTILE | B/P

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** **Result: Positive** ☐ **Negative** ☐ **mm**_____

Blood Test: Date Reported **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** Yes ☐ No ☐ Modified ☐

Print Name (MD,DO, APN, PA) Signature Date

Address Phone

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

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

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

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

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

Address: 1300 West 2nd Street, Rock Falls, IL 61071 Phone: 815-626-2230

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

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

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

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

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

List past and current medical conditions. _____

_____

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

_____

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

_____

_____

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

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

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

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

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

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

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

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

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

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

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

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

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

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

Address: 1300 West 2nd Street, Rock Falls, IL 61071 Phone: 815-626-2230

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