DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia
School-Based Health Center

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Consent for Athletic Well-Child Exam Health Services and Treatment

SBHC Health Services Provider

❑ Anacostia SHS ❑ Ballou SHS ❑ Cardozo EC ❑ Coolidge SHS ❑ Dunbar SHS ❑ Woodson SHS ❑ Roosevelt SHS

DCPS School of Enrollment _____

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Student's Social Security Number: _____-_____-_____

Sex: ❑ Male ❑ Female ❑ Other Grade _____

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

Student Address: _____
_____

Who is or will be the student's regular doctor?

Name: _____

Telephone: _____

Address: _____
_____

PARENT/GUARDIAN INFORMATION

Mother

Last Name: _____ First Name: _____

Father

Last Name: _____ First Name: _____

Legal Guardian, if applicable

Last Name: _____ First Name: _____

Relationship of legal guardian to student

❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact information for parent or guardian

Home Tel: _____ Work Tel: _____

Cell: _____

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

INSURANCE INFORMATION

Does your child have Medicaid coverage?

❑ No ❑ Yes: Medicaid ID #: _____

Which Plan?

❑ AmeriHealth Caritas DC
❑ MedStar Family Choice DC
❑ Health Services for Children with Special Health Care Needs (HSCSN)
❑ CareFirst Community Health Plan DC

Does your child have coverage through your employer or any other type of health insurance?

❑ No ❑ Yes, Health Plan: _____

Member ID/Policy Number: _____

Health Insurance Phone: _____

If your child does not have health insurance, would you like to be contacted by the clinical case manager for assistance with obtaining health insurance? ❑Yes ❑No

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the licensed health professionals at the School-Based Health Center as part of the school health program approved by the District of Columbia Department of Health (DC Health) and the District of Columbia Public Schools (DCPS.) I understand that the school-based health center will ensure confidentiality in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. School health services, including screening for vision, hearing, asthma, obesity, and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, college, daycare, sports, employment, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Reproductive health care services, including abstinence counseling, providing access to birth control, pregnancy testing, STD screening and treatment, HIV testing, PAP smears when indicated, and referrals for abnormal results, as age appropriate.
7. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and tobacco use; age appropriate education on abstinence, pregnancy prevention, sexually transmitted infections, and HIV.
8. Dental treatment consisting of examinations, x-rays, diagnosis & treatment modalities that may include cleaning, administration of topical and local anesthesia, fillings and sealants.
9. Referrals for services not provided at the school-based health center.
10. Annual health questionnaire/survey.

PLEASE REVIEW AND SIGN BOTH SIGNATURE LINES ON PAGE 2

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Consent for Athletic Well-Child Exam Health Services and Treatment

PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature below authorizes release of health information obtained by the School Based Health Center to DC Public Schools and DC Health. This information may be protected from disclosure by federal privacy law and District law. I am further authorizing the School-Based Health Center to release specific medical information to DC Public Schools and DC Health, either because it is required by law or by regulation, or because it is necessary to protect my child's health and safety.

I understand that I do not have to allow release of my child's health information in order for my child to receive treatment, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Health Center. However, after a disclosure has been made, I understand that my revocation does not cover information released prior to the revocation I also understand that health information disclosed pursuant to this authorization may be re-disclosed by the recipient, who shall provide written notification to the receiving party that this health information is being re-disclosed for the specific stated purpose, and that any additional re-disclosure will require additional consent..

I authorize the School-Based Health Center to release specific medical information of the student named on the reverse page to the DC Public Schools and DC Health.

I understand that the results of reportable diseases and immunizations administered will be released to DC Health and the DC Public Schools. In addition, case records and survey information may be used for program evaluation in accordance with Federal and District laws regarding patient confidentiality.

My signature in the Consent for Release of Health Information section below gives my consent to the School- Based Health Center to contact other providers who have examined my child and to obtain insurance information.

Time Period During Which Release of Information is Authorized:
From: Date that form is signed on opposite page **To**: Date that student is no longer enrolled in sports activities with DCPS

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

❑**YES:** I have read and understand the services listed on the previous page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the selected school-based health center for well-child exam and sports clearance as long as my child is participating in DCPS sports activities. To promote continuity of care my child will only be enrolled at ONE SBHC. I further agree that I will promptly inform the School-Based Health Center in writing of any changes in my child's physical or dental health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child.

NOTE: In accordance with the Minor's Health Consent Regulation (22-B DCMR 600), parental consent is not required for the prevention, diagnosis or treatment of (1) a pregnancy or its lawful termination; (2) substance abuse, including drug and alcohol abuse; (3) a mental or emotional health condition, or (4) a sexually transmitted disease. Furthermore, parental consent is not required for the application of emergency first aid treatment or the provision of services where the health of a student is endangered. Parental consent is not required for students who are 18 years or older or for legally emancipated students.
I hereby acknowledge and agree that, as provided for in D.C. Official Code sec. 38-651.11, the District, the school, its employees and agents, which shall include the practicing physician, physician assistant or advanced practice nurse, shall be immune from civil liability for any acts or omissions relating to or arising from their good faith performance of responsibilities under D.C Official Code sec. 38-651.01 et seq., except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form must be completed and submitted before the student can receive health services.

❑**NO:** I do not give permission for my child to receive SBHC services.

X _____ _____

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____ _____

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE REVIEW AND SIGN BOTH SIGNATURE LINES ON PAGE 2

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Consent to Share Student Health Educational Records

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student educational records. The purpose of this consent is to allow key school–based staff members *(such as the principal, school nurse, nurse case managers, 504 Coordinators, and Special Education staff members)* who work with your child to share health-related educational records with external health-related agencies and healthcare providers, including school-based health centers *(if there is one located in your school)*. These staff members and health care providers would then be able to better coordinate health-related services for your child. Coordinated services will better ensure that your child's needs are met, and that he/she can fully participate in the school's learning environment. **IF YOU AGREE TO THIS CONSENT, PLEASE COMPLETE, SIGN AND RETURN IT TO THE REGISTRAR AT YOUR CHILD'S SCHOOL.**

_____ _____ _____
(Student/Child's Name) (School Name) (Date of Birth)

_____ _____
(Grade) (Student ID, if known)

1. I authorize the District of Columbia Public Schools to share the educational records regarding my child specified in Section 3 below with each of the following agencies and organizations:

*DC Department of Health,
*DC Department of Mental Health,
*DC Department of Health Care Finance,
*DC Department of Human Services,
*Your child's health care provider(s), and
*Other health service providers who deliver services in the school

2. I understand that this information may be used ONLY for the following purposes:

* Planning and providing coordinated educational and health related services, and
* Evaluating programs serving my child and the services provided to my child.

3. I authorize the use/disclosure of each of the following records:

*School nurse records,
* IFSP/IEP documents,
* 504 Plans,
* Class schedule,
* Attendance records,
* Grades, observations and other educational information contained in student records,
* Current Medication orders (retained by the school nurse),
* Eye medical reports,
*Audiology reports, and
*Nursing care plan (as part of IEP or 504 Plan)

4. I understand that:

* This authorization is voluntary and my child will not be refused educational services if I choose not to sign it, and
* I have the right to request a copy of this form after I sign it and to see or copy any information disclosed under this consent.

5. I consent to the use/disclosure of the above information. I understand that this information may not be used for any purposes other than those stated above in Section 2. This consent may be revoked in writing by me at any time. I understand that revoking this authorization will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

_____ _____ _____
(Signature of parent/guardian/student over 18) (Relationship to the student) (Date)

This authorization expires one year from the signature date above.

UNITY HEALTH CARE
Healthier You. Healthier Communities.

Immunization Consent Form

DC Law requires each student attending a DC public school or public charter school to present valid written immunization certification, documenting that he or she has been successfully immunized in accordance with current Department of Health immunization requirements, to his/her school prior to the first day of classes. Unless you obtain a medical or religious exemption, DC law requires your child to receive the following immunizations in order to attend school. Students in grades 6-12 are also required to receive a Human Papillomavirus (HPV) vaccine or submit an opt-out form.

District of Columbia Immunization Requirements **must be documented by submitting a completed Universal Health Certificate	
Students 11 years and older entering 6th-12th Grade * All varicella/chickenpox disease MUST be verified/diagnosed by a healthcare provider & documentation must include month & year of disease *Meningococcal booster dose recommended at 16 years of age * HPV: Two (2) doses if student receives first dose between 9-14 years of age with doses separated by 6-12 months. Three (3) doses required if start series on or after 15 years of age	**(doses required)** Immunization **5** Diphtheria/Tetanus/Pertussis (DtaP/Td) **1** Tdap **4** Polio **2** Varicella (chickenpox)-if no history of disease* **2** Measles, Mumps & Rubella (MMR) **3** Hepatitis B **1** Meningococcal (Men ACWY)* **2 or 3** Human Papillomavirus Vaccine (HPV)* *or* *[parent must sign approved vaccine refusal form]*

The below student needs the following immunizations:

Name: _____DOB: _____

Vaccine Needed	Name: Vaccine or Series needed	Parent/Guardian **Signature** (sign for **EACH** Vaccine/series you give consent for)
	Required Immunizations	
	Diphtheria/Tetanus/Pertussis (DtaP/Td)	
	Tdap	
	Polio	
	Varicella (chickenpox)-if no history of disease	
	Measles, Mumps & Rubella (MMR)	
	Hepatitis B	
	Meningococcal (Men ACWY)	
	Human Papillomavirus Vaccine (HPV)	
	Recommended	
	Hepatitis A	
	Meningococcal B (Men B)	
	Influenza	

I have been given a copy and have read or had explained to me the information contained in the appropriate CDC Vaccine Information Materials (VIMs) about the vaccine(s) indicated below. I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand benefits and risk of the indicated vaccines and ask that the vaccine(s) checked below be given to the person named above for whom I am authorized to make this request. I understand that this information may be stored in the DOH Immunization Program's Registry.

Parent/Guardian Name (please print): _____

Parent/Guardian Phone number: _____Date Signed_____

***If you decline the Human Papillomavirus Vaccine (HPV), <u>sign and return</u> the vaccine refusal/Opt-out form**

CONSOLIDATED PATIENT CONSENT AND RELEASE FORM

Consent for Health Care Services/ Treatment

By signing this form, I understand the following:

- I, the undersigned patient, or the parent, spouse or legal guardian of the patient, consent to all health care services, including but not limited to, medical care, dental care, social services/behavioral health care and podiatric care, including emergency treatment provided by Unity Health Care Inc. and its employees and/or contractors.
- Health care services may include but not be limited to laboratory procedures, blood tests, immunizations, radiology examinations, remote monitoring of my health data, medical or surgical treatment or procedures rendered under the general and special instructions of my provider at Unity Health Care.
- I may be required by Unity to give a separate written consent for some treatments and procedures.
- I agree that Unity Health Care Inc. may provide me with health services in person at a clinic, health center or physical facility or via telehealth, and/or telephonically. Telehealth involves the use of electronic and telecommunications technologies used to provide care and services at-a-distance. A Telehealth service means that my visit with a Unity Health Care, Inc. staff member will happen via video conferencing by using electronic devices such as a cellular phone, tablet, or computer. Some of these health services may be only via telephone.
- I understand that if Telehealth video conferencing technology is used to provide a consultation, it will not be the same as a direct patient/health care provider visit because I will not be in the same room as my health care provider.
- I understand that a telehealth visit will save me time and transportation by enabling me to remain in my home or office while the health care provider performs a visit at a distance. I understand that there is a risk that information transmitted may not be sufficient (e.g. poor resolution of images or voice) to allow for appropriate medical decision making by the provider. I will have to travel to the clinic to have an in person visit if I decline the Telehealth service.
- I will be informed of all people who will be present during my Telehealth service. I understand that I am responsible for the privacy and security of the physical location I use for a telehealth or telephonic visit to protect the privacy and confidentiality of my conversation with the Unity Health Care provider.
- I understand that all health care services provided by Unity Health Care, such as in person visits, remote health monitoring, telehealth, and telephonic visits will be billed to me or my insurance in the customary way and according to the Unity Health fee schedule and/or coverage of my insurance policy.
- I understand that If I fail to carry out the assessment, treatment plan or follow-up care prescribed by my Unity provider, I do so at my own risk.
- I have been informed that the laws that protect privacy and the confidentiality of medical information also apply to telehealth and telephonic health services, and that no information obtained in the use of telehealth or telephonic consultations which identifies me will be disclosed to other entities without my consent.

- I have read or had this form read and/or had this form explained to me. I have been given ample opportunity to ask questions and any questions have been answered to my satisfaction. I fully understand its contents including the risks and benefits.

Patient Registration/ Self-Attestation Form

I, the undersigned patient or the parent, spouse, or legal guardian of the patient, certify under penalty of perjury that the information within the Patient Registration/ Self Attestation Form, including patient, head of household /responsible party, demographic, and insurance information, is correct.

Financial Arrangements/Guarantee of Payment:

- **Self-Pay**. I, the undersigned patient, or the parent, spouse or legal guardian of the patient, understand and agree that I am responsible for the payment of charges I incur as a result of all services provided by Unity Health Care, Inc. and its staff in person, via telehealth or telephone. I understand that discounts for essential services are available, depending on family size and income. I can ask the health center director for more information about these discounts.
- **Insurance**. I certify that I am enrolled in the following insurance/managed care company: _____ (insert name of company).

I authorize Unity Health Care to apply for benefits on my behalf for services rendered by Unity Health Care Inc. I also understand that I may be responsible for paying all co-payments and for charges for non-covered services.

Acknowledgement of Receipt of Patient Information

• I acknowledge that I have read and understand Unity Health Care's "Assignment of Benefits."

• I acknowledge that I have received a copy of Unity Health Care's "Notice of Privacy Practices and Patients' Rights and Responsibilities."

• I acknowledge that I have received information regarding "Advanced Directives."

_____ _____

Signature of the Patient Date

_____ _____

Signature of the Legal Guardian of the Patient Date

- Patient is unable to sign or acknowledge receipt of the above documents due to: _____.

_____ _____ _____

Signature of Unity Witness Name and Position Date

Patient Name (Printed): _____DOB: _____ MR/ ACCT#: _____

Guidelines for Adolescent Preventive Services
Parent/Guardian Questionnaire

Confidential (Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____

Parent/Guardian name _____ Relationship to adolescent _____

Your phone number: Home _____ Work _____

Adolescent Health History

1. Is your adolescent allergic to any medicines?
☐ Yes ☐ No If yes, what medicines? _____

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Has your adolescent ever been hospitalized overnight?
☐ Yes ☐ No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem
_____	_____
_____	_____

4. Has your adolescent ever had any serious injuries?
☐ Yes ☐ No If yes, please explain. _____

5. Have there been any changes in your adolescent's health during the past 12 months?
☐ Yes ☐ No If yes, please explain. _____

6. Please check (✓) whether your adolescent ever had any of the following health problems:
If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	☐	☐	_____	Headaches/migraines	☐	☐	_____
Allergies/hayfever	☐	☐	_____	Low iron in blood (anemia)	☐	☐	_____
Asthma	☐	☐	_____	Pneumonia	☐	☐	_____
Bladder or kidney infections	☐	☐	_____	Rheumatic fever or heart disease	☐	☐	_____
Blood disorders/sickle cell anemia	☐	☐	_____	Scoliosis (curved spine)	☐	☐	_____
Cancer	☐	☐	_____	Seizures/epilepsy	☐	☐	_____
Chicken pox	☐	☐	_____	Severe acne	☐	☐	_____
Depression	☐	☐	_____	Stomach problems	☐	☐	_____
Diabetes	☐	☐	_____	Tuberculosis (TB)/lung disease	☐	☐	_____
Eating disorder	☐	☐	_____	Mononucleosis (mono)	☐	☐	_____
Emotional disorder	☐	☐	_____	Other: _____	☐	☐	_____
Hepatitis (liver disease)	☐	☐	_____				

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
☐ Yes ☐ No ☐ Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	☐	☐	☐	_____	_____
Arthritis	☐	☐	☐	_____	_____
Birth defects	☐	☐	☐	_____	_____
Blood disorders/sickle cell anemia	☐	☐	☐	_____	_____

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	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type_____)	☐	☐	☐	_____	_____
Depression	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	_____	_____
Drinking problem/alcoholism	☐	☐	☐	_____	_____
Drug addiction	☐	☐	☐	_____	_____
Endocrine/gland disease	☐	☐	☐	_____	_____
Heart attack or stroke *before* age 55	☐	☐	☐	_____	_____
Heart attack or stroke *after* age 55	☐	☐	☐	_____	_____
High blood pressure	☐	☐	☐	_____	_____
High cholesterol	☐	☐	☐	_____	_____
Kidney disease	☐	☐	☐	_____	_____
Learning disability	☐	☐	☐	_____	_____
Liver disease	☐	☐	☐	_____	_____
Mental health	☐	☐	☐	_____	_____
Mental retardation	☐	☐	☐	_____	_____
Migraine headaches	☐	☐	☐	_____	_____
Obesity	☐	☐	☐	_____	_____
Seiures/epilepsy	☐	☐	☐	_____	_____
Smoking	☐	☐	☐	_____	_____
Tuberculosis/lung disease	☐	☐	☐	_____	_____

9. With whom does the adolescent live most of the time? *(Check all that apply.)*

☐ Both parents in same household
☐ Mother
☐ Father
☐ Other adult relative
☐ Stepmother
☐ Stepfather
☐ Guardian
☐ Brother(s)/ages _____
☐ Sister(s)/ages _____
☐ Other _____
☐ Alone

10. In the past year, have there been any changes in your family? *(Check all that apply.)*

☐ Marriage
☐ Separation
☐ Divorce
☐ Loss of job
☐ Move to a new neighborhood
☐ A new school or college
☐ Births
☐ Serious illness
☐ Deaths
☐ Other _____

Parental / Guardian Concerns

11. Please review the topics listed below. Check(✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	☐	Guns/weapons	☐
Physical development	☐	School grades/absences/dropout	☐
Weight	☐	Smoking cigarettes/chewing tobacco	☐
Change of appetite	☐	Drug use	☐
Sleep patterns	☐	Alcohol use	☐
Diet/nutrition	☐	Dating/parties	☐
Amount of physical activity	☐	Sexual behavior	☐
Emotional development	☐	Unprotected sex	☐
Relationships with parents and family	☐	HIV/AIDS	☐
Choice of friends	☐	Sexual transmitted diseases (STDs)	☐
Self image or self worth	☐	Pregnancy	☐
Excessive moodiness or rebellion	☐	Sexual identity (heterosexual/homosexual/bisexual)	☐
Depression	☐	Work or job	☐
Lying, stealing, or vandalism	☐	Other: _____	☐
Violence/gangs	☐		

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?

What is it? _____

15. Can we share your answers to Question 13 with your teen? ☐ Yes ☐ No

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

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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