

Hello,

We are excited to be able to offer free in-school sports physicals again this year. Based on feedback we received in past years, there are some requirements that we will continue to implement. If the requirements are not met, we will not be able to conduct physical exams for your students.

We ask that your school district agrees to the following:

- **Schedule all appointments.** Please have a schedule set when our providers arrive. We ask that you schedule each student for 15 minutes. We ask that we have this schedule sent to us 2 weeks prior to our scheduled date so we can arrange the coverage that will be needed based on number of students.
- **Private spaces.** Please provide a minimum of 3 private rooms to conduct the physical exams. This year we would like to use classrooms or other private areas rather than the gymnasium or other public areas.
- **Air.** If your school does not have Air Conditioning, we ask that you provide fans to keep our providers and your students comfortable during their physical exams.
- **Access to a copy machine.** Our HIM department will need to be able to make copies of paper work during the physical exams. Copies can be made by staff, we just need to take a copy with us when we leave. Please ensure they will be able to access your copy machine.
- **Distribute required forms.** Please distribute the required documentation and have all students complete the forms and bring them to their physical exam. The required forms include the Preparticipation Physical Evaluation and Consent to Treat.

If you have any questions about the above requirements, please let me know.

Please know that if the student is unable to attend the in-school sports physicals we do offer this free service at all 4 of the Primary Care Clinics during office hours.

Thank you,

Addison Reilly

Memorial Hospital of Lafayette County



MEMORIAL HOSPITAL OF LAFAYETTE COUNTY

800 Clay Street • Darlington, WI 53530 • (608)776-4466

Consent for Medical Care

Student First Name: _____ M.I. _____ Last Name: _____

Student DOB: _____ Visit Date: _____

Thank you for choosing Memorial Hospital of Lafayette County Primary Care Clinics. This Consent for Medical Care explains your responsibilities and provides your consent for us to provide treatment.

Consent to Treat

- I consent to diagnosis, medical care, and treatment that has been or may be ordered by a licensed care professional.
- I understand that all licensed healthcare professionals are responsible and liable for their own acts, orders, and omissions.
- I understand that no results of a particular examination or treatment can be guaranteed and there are risks of medical care which may include injury or death.

Results of Treatment

I understand that care, tests, and treatments may have risks. These risks can result in injury or even death. I understand that no guarantees have been made to me as to the results of diagnosis, treatments, tests or examinations.

Notice of Non-Discrimination

This hospital does not discriminate against any person on the basis of race, color, national origin, disability, sexual orientation, or age in admission, treatment, or participation in its programs, services, activities, or employment.

Consent

- I have read this consent for treatment and all of my questions have been answered to my satisfaction.
- I agree that the information I gave you about myself is correct, including my name, street address, city, state, zip code, phone numbers, email, medical history and all other information.

Patient Signature : _____ Date: _____

Guardian's Name (Print) _____

Guardian Signature (if patient is under the age of 18) _____

Relationship to patient: _____ Date: _____

■ 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 <i>Staphylococcus aureus</i> (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

- 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?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ (_____ / _____)	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (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 <ul style="list-style-type: none"> 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): Memorial Hospital of Lafayette County Date: _____

Address: 731 Clay Street, Darlington, WI 53530 Phone: (608)776-4497

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

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex assigned at birth (F, M or intersex) _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

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 above-named student 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 exam 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/guardians).

Name of health care professional (Print/Type) _____

SIGNATURE OF HEALTH CARE PROFESSIONAL (MD OR DO)/PA/APNP*: _____

Clinic Name Memorial Hospital of Lafayette County

Address/Clinic 731 Clay Street City Darlington State WI Zip Code 53530

Telephone _____ Date of Examination _____

* PHYSICIANS may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____ Telephone _____

Subscriber Member Name (Primary Insured) _____

Emergency Information

Allergies _____

Medications _____

Other Information _____

Immunizations Up to date (see attached documentation) Not up to date - specify _____

(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.
2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____



MEMORIAL HOSPITAL OF LAFAYETTE COUNTY

800 Clay Street • Darlington, WI 53530 • (608)776-4466

Consentimiento para atención médica

Nombre del estudiante: _____ M.I. ____ Apellido: _____

Fecha de nacimiento del estudiante: _____

Fecha de visita: _____

Gracias por elegir Memorial Hospital of Lafayette County Primary Care Clinics. Este Consentimiento para atención médica explica sus responsabilidades y proporciona su consentimiento para que proporcionemos tratamiento.

Consentimiento para tratar

- Doy mi consentimiento para el diagnóstico, la atención médica y el tratamiento que ha sido o puede ser ordenado por un profesional de la salud con licencia.
- Entiendo que todos los profesionales de la salud con licencia son responsables de sus propios actos, órdenes y omisiones.
- Entiendo que no se pueden garantizar los resultados de un examen o tratamiento en particular y existen riesgos de atención médica que pueden incluir lesiones o muerte.

Resultados del tratamiento

Entiendo que la atención, las pruebas y los tratamientos pueden tener riesgos. Estos riesgos pueden provocar lesiones o incluso la muerte. Entiendo que no se me han dado garantías en cuanto a los resultados del diagnóstico, tratamientos, pruebas o exámenes.

Aviso de no discriminación

Este hospital no discrimina a ninguna persona por motivos de raza, color, origen nacional, discapacidad, orientación sexual o edad en la admisión, el tratamiento o la participación en sus programas, servicios, actividades o empleo.

Consentimiento

- He leído este consentimiento para el tratamiento y todas mis preguntas han sido respondidas a mi satisfacción.
- Estoy de acuerdo en que la información que le di sobre mí es correcta, incluyendo mi nombre, dirección, ciudad, estado, código postal, números de teléfono, correo electrónico, historial médico y toda otra información.

Firma del paciente: _____ Fecha: _____

Nombre del tutor (versión impresa): _____

Firma del tutor (si el paciente es menor de 18 años): _____

Relación con el paciente: _____ Fecha: _____

■ EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN

FORMULARIO DE HISTORIAL CLÍNICO

Nota: Complete y firme este formulario (con la supervisión de sus padres si es menor de 18 años) antes de acudir a su cita.

Nombre: _____ Fecha de nacimiento: _____

Fecha del examen médico: _____ Deporte(s): _____

Sexo que se le asignó al nacer (F, M o intersexual): _____ ¿Con cuál género se identifica? (F, M u otro): _____

Mencione los padecimientos médicos pasados y actuales que haya tenido. _____

¿Alguna vez se le practicó una cirugía? Si la respuesta es afirmativa, haga una lista de todas sus cirugías previas. _____

Medicamentos y suplementos: Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume. _____

¿Sufre de algún tipo de alergia? Si la respuesta es afirmativa, haga una lista de todas sus alergias (por ejemplo, a algún medicamento, al polen, a los alimentos, a las picaduras de insectos). _____

Cuestionario sobre la salud del paciente versión 4 (PHQ-4)

Durante las últimas dos semanas, ¿con qué frecuencia experimentó alguno de los siguientes problemas de salud? (Encierre en un círculo la respuesta)

	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
Se siente nervioso, ansioso o inquieto	0	1	2	3
No es capaz de detener o controlar la preocupación	0	1	2	3
Siente poco interés o satisfacción por hacer cosas	0	1	2	3
Se siente triste, deprimido o desesperado	0	1	2	3

(Una suma ≥ 3 se considera positiva en cualquiera de las subescalas, [preguntas 1 y 2 o preguntas 3 y 4] a fin de obtener un diagnóstico).

PREGUNTAS GENERALES

(Dé una explicación para las preguntas en las que contestó "Sí", en la parte final de este formulario. Encierre en un círculo las preguntas si no sabe la respuesta).

	Sí	No
1. ¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos?		
2. ¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo?		
3. ¿Padece algún problema médico o enfermedad reciente?		
PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR	Sí	No
4. ¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio?		

PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR (CONTINUACIÓN)

	Sí	No
5. ¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio?		
6. ¿Alguna vez sintió que su corazón se aceleraba, palpitaba en su pecho o latía intermitentemente (con latidos irregulares) mientras hacía ejercicio?		
7. ¿Alguna vez un médico le dijo que tiene problemas cardíacos?		
8. ¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electrocardiografía (ECG) o ecocardiografía.		
9. Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos?		
10. ¿Alguna vez tuvo convulsiones?		

PREGUNTAS SOBRE LA SALUD CARDIOVASCULAR DE SU FAMILIA	Sí	No
11. ¿Alguno de los miembros de su familia o pariente murió debido a problemas cardíacos o tuvo una muerte súbita e inesperada o inexplicable antes de los 35 años de edad (incluyendo muerte por ahogamiento o un accidente automovilístico inexplicables)?		
12. ¿Alguno de los miembros de su familia padece un problema cardíaco genético como la miocardiopatía hipertrófica (HCM), el síndrome de Marfan, la miocardiopatía arritmogénica del ventrículo derecho (ARVC), el síndrome del QT largo (LQTS), el síndrome del QT corto (SQTS), el síndrome de Brugada o la taquicardia ventricular polimórfica catecolaminérgica (CPVT)?		
13. ¿Alguno de los miembros de su familia utilizó un marcapasos o se le implantó un desfibrilador antes de los 35 años?		
PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES	Sí	No
14. ¿Alguna vez sufrió una fractura por estrés o una lesión en un hueso, músculo, ligamento, articulación o tendón que le hizo faltar a una práctica o juego?		
15. ¿Sufre alguna lesión ósea, muscular, de los ligamentos o de las articulaciones que le causa molestia?		
PREGUNTAS SOBRE CONDICIONES MÉDICAS	Sí	No
16. ¿Tose, sibila o experimenta alguna dificultad para respirar durante o después de hacer ejercicio?		
17. ¿Le falta un riñón, un ojo, un testículo (en el caso de los hombres), el bazo o cualquier otro órgano?		
18. ¿Sufre dolor en la ingle o en los testículos, o tiene alguna protuberancia o hernia dolorosa en la zona inguinal?		
19. ¿Padece erupciones cutáneas recurrentes o que aparecen y desaparecen, incluyendo el herpes o Staphylococcus aureus resistente a la meticilina (MRSA)?		

PREGUNTAS SOBRE CONDICIONES MÉDICAS (CONTINUACIÓN)	Sí	No
20. ¿Alguna vez sufrió un traumatismo craneoencefálico o una lesión en la cabeza que le causó confusión, un dolor de cabeza prolongado o problemas de memoria?		
21. ¿Alguna vez sintió adormecimiento, hormigueo, debilidad en los brazos o piernas, o fue incapaz de mover los brazos o las piernas después de sufrir un golpe o una caída?		
22. ¿Alguna vez se enfermó al realizar ejercicio cuando hacía calor?		
23. ¿Usted o algún miembro de su familia tiene el rasgo drepanocítico o padece una enfermedad drepanocítica?		
24. ¿Alguna vez tuvo o tiene algún problema con sus ojos o su visión?		
25. ¿Le preocupa su peso?		
26. ¿Está tratando de bajar o subir de peso, o alguien le recomendó que baje o suba de peso?		
27. ¿Sigue alguna dieta especial o evita ciertos tipos o grupos de alimentos?		
28. ¿Alguna vez sufrió un desorden alimenticio?		
ÚNICAMENTE MUJERES	Sí	No
29. ¿Ha tenido al menos un periodo menstrual?		
30. ¿A los cuántos años tuvo su primer periodo menstrual?		
31. ¿Cuándo fue su periodo menstrual más reciente?		
32. ¿Cuántos periodos menstruales ha tenido en los últimos 12 meses?		

Proporcione una explicación aquí para las preguntas en las que contestó "Sí".

Por la presente declaro que, según mis conocimientos, mis respuestas a las preguntas de este formulario están completas y son correctas.

Firma del atleta: _____

Firma del padre o tutor: _____

Fecha: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

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?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (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 <ul style="list-style-type: none"> 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): Memorial Hospital of Lafayette County Date: _____

Address: 731 Clay Street Phone: (608)776-4497

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

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM – FORMULARIO DE AUTORIZACIÓN

Asociación Atlética Inter-escolar de Wisconsin – Tarjeta de Permiso Atlético

(Escriba en Imprenta)

TODOS LOS ESTUDIANTES QUE PARTICIPAN EN DEPORTES INTERESCOLARES DEBEN TENER ESTA TARJETA EN ARCHIVO EN SU ESCUELA ANTES DE PRACTICAR O PARTICIPAR

El examen físico tomado 01 de abril ya partir de entonces es válida para los dos años escolares siguientes; examen físico recibido antes del 1 de abril es válida sólo para el resto de ese año escolar y el siguiente año escolar.

Apellido _____ Nombre _____ (inicial del segundo nombre) _____ Fecha de Nacimiento _____

Edad _____ Sexo asignado al nacimiento (F, M o intersexual) _____ Grado _____ Escuela _____ Ciudad _____

Dirección _____ Teléfono _____

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 above-named student 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 exam 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/guardians).

Name of health care professional (Print/Type) _____

SIGNATURE OF HEALTH CARE PROFESSIONAL (MD OR DO)/PA/APNP*: _____

Clinic Name Memorial Hospital of Lafayette County

Address/Clinic 731 Clay Street City Darlington State WI Zip Code 53530

Telephone _____ Date of Examination _____

* Physicians may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of THE clinic with which the physician is affiliated.

Lugar de Empleo de los Padres _____

Médico de la Familia _____ Dentista de la Familia _____

Nombre de Seguros Privados _____ Teléfono _____

Nombre de Asegurado Primario _____

Información de emergencia

Alergias _____

Medicamentos _____

Otra información _____

Inmunizaciones Están al día (una copia adjunta) No están al día - específica _____

(por ejemplo, el tétanos / difteria; paperas sarampión Rubéola; hepatitis A, B; influenza; poliomielitis; neumocócica; meningocócica; varicela)

- Yo doy mi permiso al estudiante mencionado arriba para practicar y competir y representar a la escuela en WIAA deportes interescolares aprobados, excepto en los restringidos en esta tarjeta.
- De conformidad con los requisitos de la Portabilidad del Seguro de Salud y la Ley de Responsabilidad de 1996 y los reglamentos promulgados en virtud del mismo (colectivamente conocidos como "HIPAA"), autorizo a los proveedores de salud del estudiante arriba mencionado, incluyendo personal médico de emergencia y otros profesionales igualmente capacitados que pueden debe asistir a un evento o práctica interescolar, a revelar / intercambio de información médica esencial con respecto a la lesión y el tratamiento de este estudiante para el personal del distrito escolar apropiado tal como, pero no limitado a: director, director de Deportes, masajista deportivo, médico del equipo, Entrenador del equipo, Administrativo Asistente del director de Deportes y / u otros proveedores profesionales de atención de salud, a los efectos del tratamiento, la atención de emergencia y lesiones mantenimiento de registros.

FIRMA DEL PADRE/GUARDIÁN _____ Fecha _____