ELGIN ISD
ONE TOWN • ONE TEAM • ONE FAMILY

FREE PHYSICALS FOR STUDENTS

LOCATION: Elgin High School - Gymnasium

DATE: May 14, 2024

TIME: 2-7:00p

WHO IS ELIGIBLE: All current 9th, 10th, and 11th grade students who wish to participate in sports next year

- Paperwork can be picked up at the FieldHouse in the Athletic Training Room, with a Coach, or Mrs. Helton.
- **This paperwork must be filled out and returned to the Athletic Trainers or a coach no later than May 6, 2024**. Please ensure paperwork is completed in its entirety, listing medications, allergies, dates, and any other important information. Parent Signature and student signature are required in order to be included in the physical day.
- If your child is under a doctor's care for a medical condition, the doctors may not be able to clear your child's physical and they will need to have their physical done by their primary physician. Examples of these medical conditions include but are not limited to: Sickle Cell Trait or Anemia, Diabetes, Epilepsy, Asthma, Heart Disease, etc.
- Please note that a physical examination is **REQUIRED** to be completed prior to the first day of practices or school for all students who will be participating in the Athletics program.
- Transportation will not be provided for students staying after school to receive their physical. Please arrange for an alternate method of pick up.
- For questions or concerns please contact the Athletic Trainers:
    - EHS: Justin Garza - justin.garza@elginisd.net
    - EHS: Ysabel Cuellar - ysabel.cuellar@elginisd.net

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UBICACIÓN: Elgin High School - Gimnasio

FECHA: 14 de mayo de 2024

HORA: 2-7:00 p

QUIÉN ES ELEGIBLE: Todos los estudiantes actuales de los grados 9, 10 y 11 que deseen participar en deportes el próximo año.

- El papeleo se puede recoger en el FieldHouse en la sala de entrenamiento atlético, con un entrenador o la Sra. Helton.
- **Esta documentación debe completarse y devolverse a los entrenadores atléticos o a un entrenador a más tardar el 6 de mayo de 2024.** Asegúrese de completar la documentación en su totalidad, enumerando los medicamentos, las alergias, las fechas y cualquier otra información importante. Se requiere la firma de los padres y la firma del estudiante para que se incluyan en el día físico.
- Si su hijo está bajo el cuidado de un médico por una condición médica, hay una chance que los medicos no miren o no podrán aprobar el examen físico de su hijo y deberán hacer que su médico de atención primaria lo haga. Ejemplos de estas condiciones médicas incluyen pero no se limitan a: rasgo de células falciformes o anemia, diabetes, epilepsia, asma, enfermedades del corazón, etc
- Tenga en cuenta que se **REQUIERE** que se completa un examen físico antes del primer día de prácticas o escuela para todos los estudiantes que participarán en el programa de atletismo.
- No se proporcionará transporte a los estudiantes que se queden después de la escuela para recibir su examen físico. Solicite un método alternativo de recogida.
- Si tiene preguntas o inquietudes, comuníquese con los entrenadores atléticos:
    - EHS: Justin Garza - justin.garza@elginisd.net
    - EHS: Ysabel Cuellar - ysabel.cuellar@elginisd.net

EXÁMENES FÍSICOS GRATIS PARA ESTUDIANTES

CHC
of South Central Texas

Consents and Acknowledgements

In order for you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information and documents. If you have any questions about any of this information or need completing this form, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information, have been given the chance to ask questions, and are giving your consent.

GENERAL CONSENT TO TREAT

I hereby authorize the Physicians, Physician Assistant, Advance Practice Nurse, Psychologist and any other Clinical Staff on staff at this Health Center, at their service locations, and consent to care encompassing routine diagnostic procedures, examinations, medical treatment and dental treatment, if applicable. This includes, but is not limited to, routine laboratory work (such as blood, urine and other studies) including HIV, taking of x-rays, heart tracing, administration of medications, procedures, examinations, psychological testing and treatment prescribed by the medical staff (physicians, mid-level providers), and dental staff if applicable, and counseling services necessary to receive family planning services as defined by federal regulation. I understand that there are no guarantees being made to me concerning the results of my treatment or the effectiveness of any birth control methods.

I further understand that a mid-level provider (Physician Assistant, Advance Practice Nurse) is not a licensed physician and may not treat or diagnose any illness, injury, or medical and/or dental condition except under the supervision and direction of a licensed physician. I further understand that I may revoke this authorization at any time and may request to be seen by a licensed physician or their designated physician replacement.

Release of Information: I authorize this Health Center to release necessary information to third party insurance carriers for the purpose of filing insurance claims related to (his/her) care. I further authorize the release of information about my treatment here to my (his/her) doctor or any designated by me.

I have read or had read to me the **Clients and Center Rights and Responsibilities** and accept that document. I certify that this form has been fully explained to me, that I have read it, or have had it read to me, that the blank spaces have been filled in ink, and that I understand its contents.

I understand that this consent form will be valid and remain in effect as long as I attend the Health Center. I have been given an opportunity to ask questions about the services to be provided by this center and I believe that I have sufficient information to give this informed consent.

Females Only: I understand that my participation in the BCCS program will allow the Community Health Center of South Central Texas, Inc. to enter and view my information in the statewide database (MED-IT)

INTEGRATED MODEL OF CARE

The provider you are seeing integrates both physical health and behavioral health when making treatment decisions. Community Health Centers of South Central Texas works in collaboration with Bluebonnet Trails Community Services to provide primary medical, dental and behavioral health services that are integrated. I give my permission for my information to be shared between these two agencies on a need to know basis.

You are responsible for giving us accurate information about your present financial status and any changes in your financial status, insurance information, and Medicare or Medicaid eligibility are to be reported at each visit. We need this information to decide how much to charge you and/or bill private insurance, Medicaid, Medicare, or other benefits you may be eligible for. If your income is less than the federal poverty guidelines, you will be charged a discounted fee. It is the responsibility to report all changes after the initial visit and annually our staff will ask you for changes at the time of the visit.

I, _____, the undersigned, hereby authorize CHCSCT, Inc. its representatives, physicians and staff, to share any and all medical and financial information with the following individual(s).

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

☐ At this time I do not want my information shared with anyone

By signing my name below, I am acknowledging that I have read, and fully understand, each of the separate paragraphs set forth above.

Signature:	**Date:**
Printed Name: (If other than patient, print relationship)	**Date of Birth:**

PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

2024

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

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

		Yes	No
1.	Have you had a medical illness or injury since your last check up or physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexplained death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in activities for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____		
	When was your last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
	If yes, check appropriate box and explain below:		

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16.	Do you want to weigh more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

Females Only I choose not to provide written information on Question 19 but will discuss with a medical professional: ☐

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

Males Only I choose not to provide written information on Question 20 but will discuss with a medical professional: ☐

20. Are you missing a testicle? _____
Do you have any testicular swelling or masses? _____

☐ An electrocardiogram (ECG) is not required. I have read and understand the informatic about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form. By checkir this box, I choose to obtain an ECG for my student for additional cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.

EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

It is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of participation, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

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

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high participation and again prior to first and third years of high school participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **** Local district policy may require an annual physical exam.***

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only) if indicated			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for:_____Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or performance/