BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

Sports Physical Form

First Name: _____ **Last Name:** _____

DOB: _____ **Sex:** _____ **Social Security Number:**_____

Sport(s):_____

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

Have you ever had Covid-19? ☐ Yes ☐No
Have you been immunized for Covid-19? ☐ Yes ☐No
If yes, you have had: ☐ One Shot ☐Two Shots

List past and current medical conditions:

_____

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

_____

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

_____

Do you have any allergies? If yes, list all of your allergies (i.e., medicines, pollens, foods, stinging insects):

_____

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

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HEART HEALTH AND ABOUT YOU (CONTINUED)	YES	NO
9. Do you get lightheaded 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 the age of 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 (CPTV)?		
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?		
16. Has the athlete sprained, strained, dislocated, fractured, broken, had repeated swelling, or had any other injury to bones, joints, or muscles?		
17. Has the athlete ever had heat or muscle cramps?		
18. Does the athlete use any special equipment? (Pads, braces, mouthguard, etc.)		

MEDICAL QUESTIONS	YES	NO
19. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
20. Are you missing a kidney, an eye, a testicle (males only), your spleen, or any other organ?		
21. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
22. Do you have any recurring skin, rashes, or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
23. Have you had a concussion or head injury that caused confusion, a prolonged headache, or other memory problems?		
24. Have you ever had high blood pressure?		
25. Have you ever been hospitalized?		
26. Do you tire more quickly than others during activity?		
27. Do you have asthma?		
28. Since your last medical evaluation, have you had any medical problems or injuries?		
29. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
30. Have you ever become ill while exercising in the heat?		

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MEDICAL QUESTIONS (cont.)	YES	NO		EXPLAIN ANY "YES" ANSWERS HERE
31. Do you or does someone in your family have sickle cell trait or disease?				
32. Have you ever had or do you have any problems with your eyes or vision?				
33. Do you worry about your weight?				
34. Are you trying to, or has anyone recommended that you gain or lose weight?				
35. Are you on a special diet, or do you avoid certain types of foods or food groups?				
36. Have you ever had an eating disorder?				
FEMALES ONLY	YES	NO		
37. Have you ever had a menstrual period?				
38. How old were you when you had your first menstrual period?				
39. When was your most recent menstrual period?				
40. How many periods have you had in the past 12 months?				

I hear by state that, to the best of my knowledge, my answers to the questions on this form are complete and correct. Additionally, I authorize BMRHC to release the requested sports physical records directly to my child's school district and to provide any necessary information to facilitate the transfer of my records.

Signature of athlete:_____

Signature of parent or guardian:_____

Date:_____

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EXAMINATION		
Height:_____	Weight:_____	B/P:_____
Pulse:_____	Vision: **R** 20/ **L** 20/ **Both:** 20/	Corrected: YES_____ NO_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance: - Marfans stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse, and aortic insufficiency)		
Eyes, ears, nose, mouth, and throat - Pupils equal, hearing		
Lymph nodes		
Heart* - Murmurs, auscultation standing, auscultation supine, Valsalva maneuver, edema Murmurs, auscultation, standing, auscultation, supine, and with Valsalva maneuver, edema, pulses		
Lungs		
Abdomen		
Skin - Herpes simplex virus (HSV), methicillin-resistant staphylococcus aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL		
Neck		
Back		
MUSCULOSKELETAL (Cont.)	NORMAL	ABNORMAL FINDINGS
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/other		

*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings.

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for_____

☐ Not Cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports_____

Reason:_____

Recommendations:_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the provider may rescind the clearance until the problem is resolved, and the potential consequences are completely explained to the athlete, parents/guardians.

Name of Provider:_____

Address:_____

Signature of provider:_____ Date of exam:_____

BOSTON MOUNTAIN RURAL HEALTH CENTER, INC.

Name: _____ MI: _____ Last Name: _____

Address: _____City_____ State _____ Zip Code _____

Date of Birth: _____ Social Security #:_____

Home Phone: _____ Cell Phone: _____

Employer Name: _____Work Phone: _____

Emergency Contact Name: _____Relationship:_____ Phone #:_____

Primary Care Provider, *If not BMRHC PCP, obtain ROI:* _____ PCP Ph Number_____

Parent/Guardian Name:_____ Address: _____

Social Security #_____ DOB:_____

***Please complete the following section IN REGARDS TO THE PATIENT*:**

Please select the patient's **Race:**

- ☐ White/Caucasian
- ☐ Chinese
- ☐ Asian Indian
- ☐ Guamanian
- ☐ Other Pacific Islander
- ☐ African American/ Black
- ☐ Filipino
- ☐ Vietnamese
- ☐ Hispanic/White
- ☐ Japanese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Asian
- ☐ Korean
- ☐ Samoan
- ☐ American Indian
- ☐ Declined to Specify/Refuse to Report

Please select the patient's **Ethnicity:**

- ☐ Non-Hispanic/Latino
- ☐ Hispanic/Latino/a (**if yes, please select the sub-category below:**)
  - ☐ Mexican/ Mexican American
  - ☐ Hispanic/Latino/a and Spanish Combined
  - ☐ Puerto Rican
  - ☐ Cuban
  - ☐ Another Hispanic/ Latino or Spanish

- **Primary Language (Circle):** English, Indian, Spanish, Russian, Marshallese, Other
- **Marital Status (Circle):** Single, Married, Divorced, Widowed, Legally Separated, Partner, Unknown
- **Veteran (Circle):** Yes/No
- **Education Level (Circle):** Some High School, GED, High School Graduate, Some College, College Graduate
- **Communication Needs (Circle):** None, Visually Impaired, Hearing Impaired, Cognitive Impairment
- **Sex at Birth:** Male, Female, Unknown

Agricultural Worker: Yes/No, S*easonal Yes/No, Migrant Yes/No*

Homeless: Yes/No *(If "Yes," please specify: homeless shelter, street, transitional, doubling up, other)*

PROVIDE INSURANCE CARDS TO FRONT OFFICE PERSONNEL

If you have an Air Transport Membership, please list your coverage: _____

PREFERRED PHARMACY _____

Hereby certify that the above information is correct

Patient Responsible Party Signature _____ **Date**_____

BOSTON MOUNTAIN RURAL HEALTH CENTER, INC.

Nombre: _____ Inicial: _____ Apellido: _____

Dirección: _____ Ciudad _____ Estado _____ Código Postal _____

Fecha de nacimiento: _____ Seguro Social #:_____

Teléfono de casa: _____ Teléfono celular: _____

Nombre del empleador: _____ Teléfono del trabajo:_____

Nombre de contacto de emergencia: _____Relación:_____ Número de teléfono:_____ Proveedor de atención primaria,_____*Si no es el PCP de BMRHC, obtenga la forma para obtener sus reportes medicos (ROI)*Número de teléfono del PCP_____

Nombre del Padre de Familia / Guardián:_____ Dirección:_____

Número de Seguro Social _____ Fecha de Nacimiento _____

***Por favor complete la siguiente sección CON RESPECTO AL PACIENTE*:**

Por favor seleccione el paciente **Raza:**

- ☐ Blanco/Caucásico
- ☐ Chino
- ☐ Indio Asiático
- ☐ Guameño
- ☐ Otros isleños Del Pacífico
- ☐ Afroamericano/Negro
- ☐ Filipino
- ☐ Vietnamita
- ☐ Hispano/Blanco
- ☐ Japonés
- ☐ Otro asiático
- ☐ Nativo hawaiano
- ☐ Asiático
- ☐ Coreano
- ☐ Samoano
- ☐ Indio Americano
- ☐ Negarse a informar

Por favor seleccione los pacientes **Etnicidad:**

- ☐ No hispano/latino
- ☐ Hispano/Latino/a (**en caso afirmativo, seleccione la subcategoría a continuación:**)
  - ☐ Mexicano/Mexico American
  - ☐ Hispano/latino/y español combinados
  - ☐ Puertorriqueño
  - ☐ Cubano
  - ☐ Otro hispano/latino o español

- **Idioma principal (circule Uno):** inglés, indio, español, ruso, marshallese, otro
- **Estado civil (circule Uno):** Soltero, Casado, Divorciado, Viudo, Separado legalmente, Pareja, Desconocido
- **Veterano (circule uno):** Sí / No
- **Nivel educativo (circule):** Algo de escuela secundaria, GED, Graduado de escuela secundaria, Algo de universidad, Graduado universitario
- **Necesidades de comunicación (circule uno):** Ninguno, con discapacidad visual, con discapacidad auditiva, con discapacidad cognitiva
- **Barrera de transporte (circule):**Sí / No
- **Sexo al nacer:** Masculino / Femenino

Trabajador Agrícola: Sí/No*(Si responde "Sí", especifique: estacional, migrante, trabajador agrícola empleado, trabajador agrícola desempleado)*

Sin hogar: Sí/No*(Si responde "Sí", especifique: refugio para personas sin hogar, calle, transición, alojamiento doble, otro)*

PROPORCIONAR TARJETAS DE SEGURO AL PERSONAL DE LA OFICINA PRINCIPAl

Si tiene una Membresía de Transporte Aéreo, indique su cobertura: _____

FARMACIA PREFERIDA _____

Por la presente certifico que la información anterior es correcta

Firma de la parte responsable del paciente _____Fecha_____

Form Last Updated: 12/6/23, 6/26/24,

10/24,7/15

BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

ADULT & MINOR
CONSENT TO TREATMENT/TELEHEALTH CONSENT

_____

Patient Name -PRINT

I hereby consent, for myself or for whom I am legally responsible for, to receive outpatient services provided by Boston Mountain Rural Health Center, Inc. ("BMRHC"), including, but not limited to the examination, diagnosis, and treatment. I understand that this consent remains in effect so long as I am a patient of BMRHC, and I understand I may discontinue services at any time.
Our center requires that a parent or guardian give specific permission if a minor child will receive treatment when the child is accompanied by someone other than the parent or guardian. When a parent or legal guardian is not immediately available and advanced consent has not been provided, emergency care will not be delayed, but verbal consent and authorization will be required as quickly as possible for treatment.

Complete for Minor, if applicable:

If I am unable to be present for my child's visit, the person(s) listed here is/are authorized by me to accompany my child to their visits and sign any necessary consents or acknowledgements on my behalf, including responsibility for payment. **I understand that individuals that accompany my child Must be 18 or Older.**

Name: _____Relationship: _____Contact#_____

Name: _____Relationship: _____Contact#_____

Complete for School Based Health Centers:

As the parent/guardian, I grant permission for school personnel to transport and/or accompany the above named student to BMRHC visits and as with other health related matters, health information cannot be released without consent. If sports physicals are completed, I give consent to release to my child's school.

Telehealth/Video Conference Services

I agree to participate in the telemedicine consult, in which my image and my Protected Health Information (PHI) will be transmitted electronically through the videoconference(s) to health care professionals that are authorized to receive such information for the purpose of providing medical diagnostic assessment and treatment services.

I understand that the software system is encrypted, so the likelihood of this transmission being intercepted by unauthorized persons is EXTREMELY small. I understand that I can withdraw my permission at any time prior to the videoconference and/or my interrupt the videoconference at any time. In either case, I understand that no action will be taken against me, and I may still pursue a consultation in person with a physical or other health care professional. I also understand that if I interrupt the videoconference, the consultation will be incomplete. Therefore, I understand that health care professionals involved in the video conference will be unable to provide treatment or services to me at that time.

I understand that there are limits to Telemedicine Technology. Therefore, there is no guarantee that this Telemedicine session will eliminate the need for me to see a specialist in person in order to receive appropriate or additional treatment for my current condition.

Notification of Privacy

I have received a copy, read, and understand the BMRHC Notice of Privacy Practices. Please be aware that BMRHC's behavioral health services are designed to provide treatment only. Treatment services offered must be medically necessary. Copies of Independent Licensed Practitioner (ILP) and behavioral health service rules are available to patients upon request.

Authorization to Release Information

I hereby authorize BMRHC to release any necessary information acquired in the course of my examination or treatment to any authorized agent related to treatment, payment, or healthcare operations. I further authorize the ability to view prescriptive history from external sources. I further authorize the release of health information to federal and state governing entities for the purposes of required reporting.

Authorization to Pay Benefits

I authorize the clinic to release medical, dental, behavioral health or other such information to the third party insurance carriers for the purposes of filing insurance claims related to my care and understand that I may be billed for services rendered.

Acknowledgement

I acknowledge that I am responsible for the payment of the account balance. I understand that third party service payments may be denied based on the third-party payer's policies and rules. I agree to be responsible for all amounts not covered by my insurance.

By signing below, I am acknowledging that I am the patient or the authorized representative for the patient.

_____ _____

Patient Signature or Designated Representative (If minor, Parent or Legal Guardian Date

ADULTO Y MENOR
CONSENTIMIENTO PARA TRATAMIENTO/TELESALUD

_____
Nombre del paciente -IMPRIMIR

Por la presente doy mi consentimiento para servicios médicos proveídos por Boston Mountain Rural Health Center, Inc. ("BMRHC"), incluyendo pero no limitados a, examen diagnóstico, tratamiento medido y servicios de salud de comportamiento. Entiendo que este consentimiento permanecerá vigente mientras sea paciente de BMRHC, y entiendo que puedo descontinuar los servicios a cualquier momento.
Nuestro centro requiere que un guardián de un permiso específico si un niño menor recibirá tratamiento cuando el niño esté acompañado por alguien que no sea el padre o guardián. Cuando el padre o guardián legal no está disponible de inmediato y el consentimiento previo no ha sido proveído, la atención de emergencia no se trazará, pero se requiriera el consentimiento y la autorización verbales lo antes posible para el tratamiento.

Completar para Menor, si es aplicable:

Si yo no estoy disponible para presentarme para la cita de mi niño, las personas listadas en esta forma están autorizadas en mi nombre para acompañar a mi niño para su visita y firmar los consentimientos necesarios y reconocerlos en mi nombre, incluyendo la responsabilidad del pago. **Yo entiendo que la persona que se haga presente con mi niño debe ser mayor de 18 años.**

Nombre: _____ **Relación:** _____ **Número de contacto:** _____

Nombre: _____ **Relación:** _____ **Número de contacto:** _____

Completar para clínicas ubicadas en la escuelas:

Como el padre/guardián le doy permiso para la escuela personal para que transporte y acompañe al estudiante mencionado anteriormente a las visitas de BMRHC. Igual que con asuntos relacionados con la salud, la información de salud no puede divulgarse sin consentimiento. Si los exámenes físicos deportivos son completos, le doy consentimiento a la escuela de mi hijo.

Telesalud/conferencia por video

He recibido una copia, leído y entendido las regulaciones de telesalud. Yo entiendo y estoy de acuerdo en participar en telesalud, en que mi imagen y información de salud protegida (PHI) va ser transmitida electrónicamente por conferencia en video para profesionales de salud que están autorizados a recibir información para el propósito de proveer diagnósticos médicos y servicios de tratamiento.

Entiendo que las redes sociales son encriptadas y los riesgos de que la transmisión sea localizada por una persona sin autorización es extremadamente pequeña. Entiendo que puedo retirar mi permiso en cualquier momento antes de iniciar la conferencia de video o interrumpir la conferencia de video en cualquier momento. En cualquier caso, yo entiendo que ninguna acción va ser tomada contra mi nombre, y todavía puedo consultar una consultación en persona para un físico o cuidado de salud. También entiendo si interrumpo la conferencia en video la consultación va ser incompleta, en ese caso entiendo que los profesionales de salud no van a poder ofrecerme tratamiento.
Entiendo que hay límites para la tecnología de telesalud, entonces no me pueden garantizar que la sesión de telesalud va eliminar la opción que sea visto por un especialista en persona para recibir el tratamiento adecuado para mi condición.

Notificación de Privacidad

He recibido una copia, leído y entendido el aviso de privacidad BMRHC. Por favor de estar consciente que los servicios de BMRHC para la salud de comportamiento son designados para proveer tratamiento solamente. Los servicios de tratamiento que se ofrecen tienen que ser médicamente necesarios. Copias de practicantes independientes y de salud de comportamiento son disponibles solo si son solicitadas por el paciente.

Autorización para divulgar información

Autorizo a Boston Mountain liberar cualquier información necesaria adquirida en el curso de examen o tratamiento del paciente a cualquier agente autorizado relacionado con el tratamiento, el pago o las operaciones de atención médica.

Autorización para pagar beneficios .

Autorizo que la clínica libere información médica, dental, salud de comportamiento o cualquier otra información a terceros aseguranza para el propósito de presentación de reclamo de seguro relacionado a mi cuidado y entiendo que pueda ser facturado por los servicios prestados.

Reconocimiento.

Reconozco que soy responsable por el balance de mi cuenta. Entiendo que servicios terceros pueden negar pagar conforme sus pólizas de pago y reglas. acepto que soy responsable por el costo que no cubre mi aseguranza.

Firmando aquí, reconozco que soy el paciente o el representante autorizado por el paciente.

_____

Firma del paciente o el representante designado (si es menor, padre o guardián legal)

_____Fecha