Rockford Public Schools

Quality Community – Quality Schools

Together Building a Tradition of Excellence

Athletics Department
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4100 Kroes Street, NE · Rockford, MI 49341
Phone: 616.863.6040 · Fax: 616.866.7128

ATTENTION ALL 2019-2020 ATHLETES:

Are you participating in a sport next year? You need to get your physical! Get your FREE sports physical on the Spectrum Health Annual Sport Physical Day!

Date: Saturday June 8th, 2019

Location: 4100 Lake Dr. SE, Suite 300

Time: Last Name A-K - 8:00 AM; Last Name L-Z - 8:30 AM

Cost: FREE

Who is this for: All CURRENT Rockford 8th-11th Grade Athletes ONLY

What to bring: Must have COMPLETED MHSAA Physical Form with you

NO registration or fee – go directly to 4100 Lake Drive on June 8th at your designated time with your completed MHSAA physical form and receive your free sports physical.

Need transportation? RHS will provide round trip transportation via bus from the RHS parking lot. Students MUST sign up for the transportation at the following link:

https://www.signupgenius.com/go/20f0444aaa628a7fb6-bussign1

Bus information with departing times listed below:

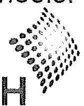
(bus will load by the athletic steps)

Last Name A-K: Bus leaves RHS at 7:30 AM – Physicals begin at 8:00 AM

Last Name L-Z: Bus leaves RHS at 8:00 AM – Physicals begin at 8:30 AM

MHSAA requires all 2019-20 athletes to have a physical dated on or after April 15, 2019 on file with the RHS Athletic Office

To help ensure a smooth process, we ask that parents complete the MHSAA Physical Form accurately and completely. This form must then accompany your son/daughter on the physical day. We will not be able to complete the physical exam without this form completed with signed parental consent. After the physical exam process is complete, the forms will be collected in the office and returned to the schools.



SPECTRUM HEALTH
The Medical Group

Sports Medicine 2019 to 2020 High School Athletic Preparticipation Physicals

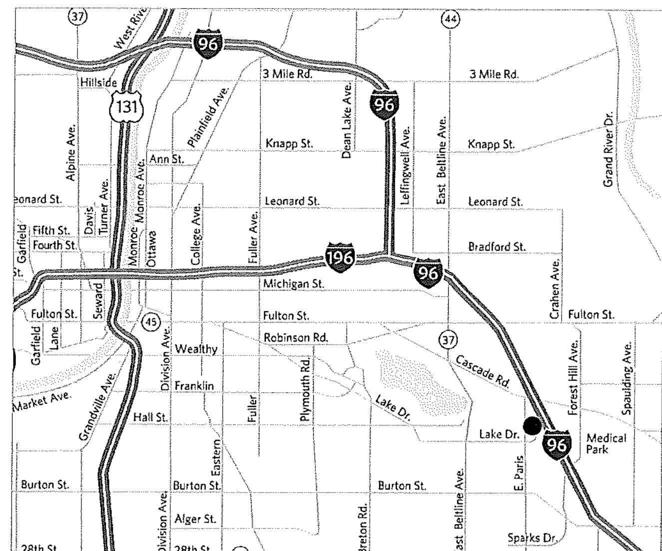
Spectrum Health is pleased to offer athletic preparticipation physical examinations (sports physical) on June 8, 2019. This service is provided to you as part of the comprehensive sports medicine program offered in your school.

Schools will have an assigned time for students to receive their physical. Please contact your school's athletic director or athletic trainer for further information on a specific time.

In order to receive a sports physical please complete the following:

- Michigan High School Athletic Association (MHSAA) physical exam form
  - Can be obtained at your school's athletic office
- Signed consent from a parent or legal guardian
- Parent or legal guardian emergency contact information

Physical exams will not be completed without the required materials.



4100 Lake Drive SE, Suite 300
Grand Rapids, MI 49546

Spectrum Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
[81 FR 31465, May 16, 2016; 81 FR 46613, July 18, 2016]

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.359.1607 (TTY: 711).

إذا كنت تتحدث اللغة العربية، فبإمكانك الحصول على المساعدة اللغوية المتاحة مجانًا. اتصل على الرقم 1.844.359.1607 (TTY: 771).

FY19.11.4.L © Spectrum Health 02.2019

SPECTRUM HEALTH
Medical Group

Consent
GENERAL, TREATMENT AND RELEASE OF INFORMATION - MEDICAL GROUP

Patient printed name ______________________________

Medical record number ____________ Account number ____________ Date ____________

NOTICE OF NONDISCRIMINATION:

Spectrum Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Spectrum Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. See pages 3 and 4 for the complete notice of nondiscrimination as well as availability of language assistance.

I AGREE:

- To the care and treatment the doctor and other healthcare professionals have ordered. The doctor may have help from other healthcare professionals.
- That the doctor may change my care to benefit my life or health.
- If I am here to give birth, the doctor and other healthcare professionals may give care to my baby.

I UNDERSTAND THAT:

- I will ask questions.
- No one has made promises about the results of my treatment or care.
- Students and staff may see me and look at my medical record for teaching or research purposes.
- The staff will double-check who I am. They will ask what I am having done. This is to protect me.
- Some doctors and staff are not employees of Spectrum Health. I know that Spectrum Health is not responsible for their care or other actions. I also know I will receive separate bills from them even though they provide services to me at a Spectrum Health location. I will work with their offices to answer questions about my insurance.
- Michigan law allows healthcare providers to test my blood for HIV (AIDS virus) or Hepatitis without my consent if someone who has helped in my care is exposed to my blood or body fluids.
- A copy of the Spectrum Health Financial Assistance Eligibility Policy is available upon request at all Registration Areas and on our website at www.spectrumhealth.org.
- Spectrum Health will not tolerate discrimination against my doctor, other healthcare professionals or staff because of race, color, gender, national origin, age, disability, sex or any other basis prohibited by federal, state or local law.

MY MEDICAL INFORMATION

- SPECTRUM HEALTH MAY RELEASE MY MEDICAL INFORMATION TO:
  - Insurance companies, health plans and administrators for payment of services I receive.
  - Government agencies like Medicare and Medicaid or as required by law.
  - My doctors and others involved in my care now or in the future.
  - My employer, if the records are related to care or services paid for by my employer, or for other purposes that are allowed under law.
  - Any person or entity responsible to pay all or part of my bill.
- I agree that Spectrum Health can take my picture and save it to my electronic medical record. I understand that Spectrum Health will use this picture for identification purposes with the goal of improving my patient experience as I move throughout the Spectrum Health system.
- I understand Spectrum Health will keep my medical information according to State law, Federal law and policy. I also understand that my medical information may be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically. This includes my diagnosis (what is wrong with me), treatments (what we are doing to make me better), and medicine or prescription information about my mental health, infectious diseases like HIV, and other problems like drug or alcohol use may be included.
- In some cases, Spectrum Health is required by law to report medical information to an agency like the health department. This may include information about HIV, TB and other diseases.

OVER →

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

GENERAL, TREATMENT AND RELEASE OF INFORMATION - MEDICAL GROUP *(CONTINUED)*

PRIVACY NOTICE

- I have rights and responsibilities when I receive services. Spectrum Health has given me its Notice of Privacy Practices, and I have had an opportunity to ask questions about the information in the Notice.

VALUABLES

- Spectrum Health would like its patients to leave valuables at home or with family members. I agree Spectrum Health is not responsible for safeguarding my property.

CONSENT TO CALL

- I have provided residential and/or cellular telephone numbers and an email address to Spectrum Health. I consent to receive autodialed and/or pre-recorded telephone calls, text messages and/or emails from Spectrum Health and/or its agents/third parties at any of these phone numbers for communication including billing purposes. I understand that my consent to call is not a condition of my treatment.

AUTHORIZATION TO RECEIVE PAYMENT

- Spectrum Health is authorized to act on my behalf in the collection of benefits from any third party and in the endorsement of checks payable to me and/or Spectrum Health. I understand that Spectrum Health is authorized to seek payment from any third party and from me.

ASSIGNMENT

- I assign Spectrum Health:
    - All benefits, claims, and any and all other rights, including the right to bill and talk to any third party for the purpose of seeking payment.
    - The right to file suit or intervene in any lawsuit or proceeding which involves my charges at Spectrum Health.
    - The right to take any other action seeking payment of my Spectrum Health charges.
- This assignment includes, but is not limited to, the right to appeal the denial of payment of my Spectrum Health charges from any payer, including any employer-sponsored benefit plan, insurance policy or insurance coverage provided by law or contract. I authorize Spectrum Health to act on my behalf to pursue an ERISA benefit claim or to appeal an adverse benefit determination. I agree to assist Spectrum Health in the pursuit of all insurance benefits and agree to pay all co-insurance, co-payments and deductibles required by any insurance plan.
- I also assign to Spectrum Health, and agree that I waive, any and all rights to settle, release or retain payment of my Spectrum Health charges, or take any other action which would in any way compromise payment or reimbursement of my Spectrum Health charges.

BILLING

- I authorize any insurance company, responsible for payment of my medical care and treatment, to pay Spectrum Health for the services given. I understand that I am responsible for any charges not covered by insurance.
- I agree that if my account is not paid when due, and the hospital should retain a lawyer and/or collection agency for collection, I will be responsible to reimburse the hospital for all costs, charges and fees associated with the collection of the amount due including, but not limited to, reasonable interest, legal costs in the event suit is filed and reasonable lawyer fees and/or reasonable collection agency fees including those based on a percentage of the debt.

PATIENT SIGNATURE(S)

I have read this form and I understand it. All my questions have been answered.

TIME __________ ☐AM ☐PM **DATE** __________ Patient signature ______________________________

- Patient is under 18 years of age or otherwise unable to consent because ______________________________

TIME __________ ☐AM ☐PM **DATE** __________ Parent/Legal Guardian/Patient Advocate/Next of Kin signature ______________________________

Printed name ______________________________

STAFF SIGNATURE(S)

TIME __________ ☐AM ☐PM **DATE** __________ Witness ______________________________

SECOND WITNESS NEEDED FOR VERBAL CONSENT

TIME __________ ☐AM ☐PM **DATE** __________ Witness ______________________________

INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, ______________________________, all oral presentations made by all of those present during the informed consent discussion.

TIME __________ ☐AM ☐PM **DATE** __________ Interpreter signature ______________________________

Interpreter name (print) ______________________________

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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CONTINUED

SPECTRUM HEALTH
Medical Group

GENERAL, TREATMENT AND RELEASE OF INFORMATION - MEDICAL GROUP *(CONTINUED)*

Patient printed name ______________________________

Medical record number ______________ Account number ______________ Date ______________

NOTICE OF NONDISCRIMINATION:

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SPECTRUM HEALTH:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Spectrum Health Language Services at 616.267.9701, 1.844.359.1607 (TTY:711).

If you believe that Spectrum Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex:

- You can file a grievance with:
  Director, Patient Experience
  100 Michigan Street NE, MC 006
  Grand Rapids, MI 49503
  616-391-2624 or toll free: 1-855-613-2262
  patient.relations@spectrumhealth.org
  You can file a grievance in person, by mail or by email. If you need help filing a grievance, the Director of Patient Experience is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW, Room 509F, HHH Building
  Washington, DC 20201
  1-800-368-1019 or 800-537-7697 (TDD)
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

CONTACT US:

Español (*Spanish*)
ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-359-1607 (TTY: 711).

العربية (*Arabic*)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-359-1607 (رقم هاتف الصم والبكم: 711).

注注 (*Chinese*): 注注/注注注 (*Mandarin*), 語語 (*Cantonese*)
注注可：可可可可中可，你可請請請撥譯請語請務助服務。請撥打 1-844-359-1607（TTY 手語翻譯：711）。

Tiếng Việt (*Vietnamese*)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-359-1607 (TTY: 711).

Ako govorite srpsko *(Serbian, Croatian or Bosnian)*
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-359-1607 (TTY: 711). (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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MEDICAL HISTORY: Completed by Parent or Guardian or 18-Year-Old

Student Name: ______________________ Date of Birth: ______________

Doctor: ______________ Doctor's Phone: ______________ Date of Exam: ______________

GENERAL QUESTIONS	Y	N
Has a doctor ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical conditions? If so, please identify below:		
❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections ❑ Other:		
Have you ever spent the night in the hospital or have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Y**	**N**
Have you ever passed out or nearly passed out DURING or AFTER exercise?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have any heart problems? Check all that apply:		
❑ High blood pressure ❑ Heart murmur ❑ Heart infection ❑ High cholesterol		
❑ Kawasaki disease ❑ Other:		
Has a doctor ordered a test for your heart? (example, ECG/EKG, echocardiogram)		
Do you get lightheaded or feel more short of breath than expected during exercise?		
Do you have a history of seizure disorder or had an unexplained seizure?		
Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Y**	**N**
Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
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)?		
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?		
BONE AND JOINT QUESTIONS	**Y**	**N**
Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?		
Have you ever had any broken or fractured bones, dislocated joints or stress fracture?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
Do you regularly use a brace, orthotics or other assistive device?		
Do you have a bone, muscle or joint injury that bothers you?		
Do any of your joints become painful, swollen, feel warm or look red?		
Do you have any history of juvenile arthritis or connective tissue disease?		
Have you ever had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?		

MEDICAL QUESTIONS	Y	N
Do you cough, wheeze or have difficulty breathing during or after exercise?		
Have you ever used an inhaler or taken asthma medicine?		
Is there anyone in your family who has asthma?		
Were you born without, or missing a kidney, eye, testicle (males), spleen or any other organ?		
Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis (mono) within the last month?		
Do you have any rashes, pressure sores or other skin problems?		
Have you had a herpes or MRSA skin infection?		
Do you have headaches or get frequent muscle cramps when exercising?		
Have you ever become ill while exercising in the heat?		
Do you or someone in your family have sickle cell trait or disease?		
Have you had any problems with your eyes or vision or any eye injuries?		
Do you wear glasses or contact lenses?		
Do you wear protective eyewear such as goggles or a face shield?		
Immunization History: Are you missing any recommended vaccines?		
Do you have any allergies?		
Have you ever had a head injury or concussion?		
Do you have any concerns that you would like to discuss with a doctor?		
Have you ever received a blow to the head that caused confusion, prolonged headache or memory problems?		
Have you ever had numbness, tingling, weakness or inability to move your arms or legs after being hit or falling?		
Have you ever had an eating disorder?		
Do you worry about your weight?		
Are you trying to or has anyone recommended that you gain or lose weight?		
Are you on a special diet or do you avoid certain types of foods?		
FEMALES ONLY (Optional)	**Y**	**N**
Have you ever had a menstrual period?		
How old were you when you had your first menstrual period?		
How many periods have you had in the last 12 months?		

CURRENT-YEAR PHYSICAL = GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

PHYSICAL EXAMINATION & MEDICAL CLEARANCE: Completed by MD, DO, PA or NP - RETURN DIRECTLY TO PATIENT

EXAMINATION: Height: Weight: ❑ Male ❑ Female BP: / Pulse: Vision: R 20/ L 20/ Corrected: ❑ Y ❑ N

MEDICAL	NORMAL	ABNORMAL
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat: Pupils Equal Hearing		
Lymph nodes		
Heart: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)		
Pulses: Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin: HSV: Lesions suggestive of MRSA, tinea corporis		
Neurologic		

MUSCULOSKELETAL	NORMAL	ABNORMAL
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional Duck Walk		

RECOMMENDATIONS: ______________________

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities NOT crossed out below.

BASEBALL – BASKETBALL – BOWLING – COMPETITIVE CHEER – CROSS COUNTRY – FOOTBALL – GOLF – GYMNASTICS – ICE HOCKEY
LACROSSE – SKIING – SOCCER – SOFTBALL – SWIMMING/DIVING – TENNIS – TRACK & FIELD – VOLLEYBALL – WRESTLING

EXAMINER

Name of Examiner (print/type): ______________________ Date: ______________

Signature of Examiner: ______________________ (Check One): ❑ MD ❑ DO ❑ PA ❑ NP

- - - - - - (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) - - - - - -

EMERGENCY INFORMATION: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

Student: ______________ Grade: ______ Doctor: ______________ Phone: (_____)______________

IN EMERGENCY (1): ______________ Home #: (_____)______________ Cell #: (_____)______________

IN EMERGENCY (2): ______________ Home #: (_____)______________ Cell #: (_____)______________

Drug Reactions: ______________ Current Medications: ______________

Allergies: ______________________

PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE

Shaded headline areas are to be completed by student, parent/guardian or 18-year-old

There are **FOUR** (4) signatures on this page (4) to be completed by student, parent/guardian and/or 18-year-old

A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

Student Name: ____
LAST FIRST MIDDLE INITIAL

Student Address: ____
STREET CITY ZIP

Gender: ❑ M ❑ F Age: _____ Date of Birth: ____________________ Place of Birth (City/State): ____________________

School: ____ Circle Grade: **6 7 8 9 10 11 12**

Father/Guardian Name: ____

Phone (home): ____________________ (work): ____________________ (cell): ____________________

Mother/Guardian Name: ____

Phone (home): ____________________ (work): ____________________ (cell): ____________________

Email Address: Parent/Guardian/18-Year-Old: ____

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, **I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements.**

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: **that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume;** and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

(1) Signature of **STUDENT**: ______________________________ Date: ______________

(2) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: ______________________________ Date: ______________

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: ❑ YES ❑ NO

If YES, Family Insurance Co: ____________________ Insurance ID #: ____________________

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

(3) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: ______________________________ Date: ______________

- - - - - - - - - - (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) - - - - - - - - - -

MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, ______________________________, an 18-year-old, or the parent or guardian of ______________________________, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

(4) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: ______________________________ Date: ______________