Mitchell County Regional Health Center
Parent/Guardian Vaccine Permission

IMMUNIZATIONS

TDAP (tetanus, diphtheria, and pertussis) required for entrance Grade 7 _____

Varicella (Chicken Pox) 2 doses required or date of illness _____

**signed consent required for females

MMR (Measles, Mumps & Rubella) 2 doses required _____

**signed consent required for females

Meningococcal (A, C, W, Y) (required Grade 7 & 12) _____

Hepatitis A 2 doses 6 months apart _____

HPV (Gardasil 9) _____

2-3 dose series depending on age and time frame between vaccines

Females age 9-26 signed consent required

Men B (Bexsero) 2 dose series (age 16-18) _____

Impact testing:

Baseline test-important in diagnosing & managing concussions _____

We recommend that you check your insurance benefits for immunization coverage prior to appointment.

Please initial by the insurance that applies to your child:

My insurance covers the cost of immunizations _____

All clinics offer VFC immunizations for uninsured, underinsured, American Indian, & Alaskan Native; TXIX, Amerigroup and Iowa Total Care insurance

Please initial if this applies to your child. _____

Signature on line below: I agree to the immunizations &/or IMPACT testing that I initialed and give permission to administer the immunizations above that are initialed.

Parent/Guardian Signature: _____Date:_____

IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

ARTICLE VII 36.14(1) PHYSICAL EXAMINATION. **Every year each student (grades 7-12) shall present to the student's superintendent a certificate *signed* by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, qualified doctor of chiropractic, licensed physician assistant, or advanced registered nurse practitioner, to the effect that the student has been examined and may safely engage in athletic competition. *This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.***

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)

Student's Name _____ Male ___ Female ___ Date of Birth _____ Grade _____

Home Address (Street, City, Zip) _____ School District_____

Parent's/Guardian's Name _____ Date _____ Phone #_____

Family Physician _____ Phone # _____

HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the other side of this form after the examination.)

	Yes	No	Does this student have / ever had?
1.	_____	_____	Allergies to medication, pollen, stinging insects, food, etc.?
2.	_____	_____	Any illness lasting more than one (1) week?
3.	_____	_____	Asthma or difficulty breathing during exercise?
4.	_____	_____	Chronic or recurrent illness or injury?
5.	_____	_____	Diabetes?
6.	_____	_____	Epilepsy or other seizures?
7.	_____	_____	Eyeglasses or contacts?
8.	_____	_____	Herpes or MRSA?
9.	_____	_____	Hospitalizations (Overnight or longer)?
10.	_____	_____	Marfan Syndrome?
11.	_____	_____	Missing organ (eye, kidney, testicle)?
12.	_____	_____	Mononucleosis or Rheumatic fever?
13.	_____	_____	Seizures or frequent headaches?
14.	_____	_____	Surgery?
15.	_____	_____	Chest pressure, pain, or tightness with exercise?
16.	_____	_____	Excessive shortness of breath with exercise?
17.	_____	_____	Headaches, dizziness or fainting during, or after, exercise?
18.	_____	_____	Heart problems (Racing, skipped beats, murmur, infection, etc.?)
19.	_____	_____	High blood pressure or high cholesterol?
20.	_____	_____	Head injury, concussion, unconsciousness?
21.	_____	_____	Headache, memory loss, or confusion with contact?
22.	_____	_____	Numbness, tingling or weakness in arms or legs with contact?
23.	_____	_____	Severe muscle cramps or illness when exercising in the heat?
24.	_____	_____	Fracture, stress fracture or dislocated joint(s)?
25.	_____	_____	Injuries requiring medical treatment?
26.	_____	_____	Knee injury or surgery?
27.	_____	_____	Neck injury?
28.	_____	_____	Orthotics, braces, protective equipment?
29.	_____	_____	Other serious joint injury?
30.	_____	_____	Painful bulge or hernia in the groin area?
31.	_____	_____	X-rays, MRI, CT scan, physical therapy?
32.	_____	_____	**Has a doctor ever denied or restricted your participation in sports for any reason?**
33.	_____	_____	**Do you have any concerns you would like to discuss with your health care provider?**

	Yes	No	Family History:
34.	_____	_____	Does anyone in your family have Marfan syndrome?
35.	_____	_____	Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50?
36.	_____	_____	Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
37.	_____	_____	Has anyone in your family had unexplained fainting, seizures, or near drowning?
38.	_____	_____	Does anyone in your family have asthma?
39.	_____	_____	Do you or someone in your family have sickle cell trait or disease?

*Use this space to explain any **"YES"** answers from above (questions #1-38) or **to provide any additional information**:*

_____

_____

40. Are you allergic to any prescription or over-the-counter medications? *If yes, list:* _____

41. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
A. _____ B. _____ C. _____

42. Year of last known vaccination: Tdap (Tetanus): _____ Meningitis: _____ Influenza: _____

43. What is the most and least you have weighed in the past year? ***Most*** _____ ***Least***

44. Are you happy with your current weight? ***Yes*** _____ ***No*** _____ ***If no***, how many pounds would you like to lose or gain?
Lose _____ *Gain* _____

FOR FEMALES ONLY:

1. How old were you when you had your first menstrual period? _____

2. How many periods have you had in the last 12 months? _____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed medical professional as designated in Article VII 36.14(1).

Athlete's Name _____ Height _____ Weight _____

Pulse _____ Blood Pressure _____/_____ *(Repeat, if abnormal _____/_____)* Vision R 20/_____ L 20/_____

	NORMAL	***ABNORMAL FINDINGS***	***INITIALS***
1. Appearance (esp. Marfan's)			
2. Eyes/Ears/Nose/Throat			
3. Pupil Size (Equal/Unequal)			
4. Mouth & Teeth			
5. Neck			
6. Lymph Nodes			
7. Heart (Standing & Lying)			
8. Pulses (esp. femoral)			
9. Chest & Lungs			
10. Abdomen			
11. Skin			
12. Genitals - Hernia			
13. Musculoskeletal - ROM, strength, etc. *(See questions 24-31)*			
14. Neurological			

Comments regarding abnormal findings: _____

_____

_____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS

(Please be precise when indicating at which level the student is cleared to participate.)

1. _____ **FULL & UNLIMITED PARTICIPATION**
2. _____ **LIMITED PARTICIPATION** - *May **NOT** participate in the following (checked):*

   _____ Baseball _____ Basketball _____ Bowling _____ Cross Country _____ Football _____ Golf _____ Soccer

   _____ Softball _____ Swimming _____ Tennis _____ Track _____ Volleyball _____ Wrestling
3. _____ **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** _____
4. _____ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE** _____

_____ _____

Licensed Medical Professional's Name *(Printed)* **Date of PPE**

_____ _____

Licensed Medical Professional's Signature **Phone**

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I hereby **verify** the accuracy of the information on the opposite side of this form and **give my consent** for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I **also give my permission** for the team's physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury/illness and to share necessary information about the injury/illness with appropriate school personnel.

_____ _____

Name of Parent or Guardian, or student if 18 years of age *(Printed)* Signature of Parent of Guardian, or student if 18 years of age

_____ _____

Address (Street/PO Box, City, State, Zip) Phone Number

This form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for use by the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. Schools are encouraged NOT to change this form from its published format. Additional school forms can be attached to this form. *08/15*

Dear Parent/Guardian,

Mitchell County Regional Health Center is concerned about your student-athlete's health. In the event of a possible head injury, such as a concussion or an incident causing concussion-like symptoms, the Physical Therapy Department and Osage Clinic work together to help your student-athlete safely return to action.

In order to better manage concussions sustained by our student-athletes, we use a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many professional, collegiate, and high school sports programs across the country to successfully diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of the head injury and when the injury has fully healed.

This non-invasive test takes about 20-30 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test.

How the ImPACT program works:

1) **BASELINE:** First, your athlete takes the BASELINE test. Ideally this is done pre-season, but can be done anytime. It provides data on how your athlete's healthy brain performs. The BASELINE test is good for two years. Regarding the regular ImPACT test, it is recommended to take the first BASELINE in 7th grade, and then take a new BASELINE in 9th and 11th grades (there is a pediatric test for younger ages).
2) **POST-TEST:** If a concussion is suspected, the athlete then takes a POST-TEST. This provides data of how the injured brain is performing. The medical and physical therapy staff can then compare the BASELINE to the POST-TEST to better evaluate the injury and determine when return-to-play is appropriate and safe for your injured athlete. **This makes the BASELINE test very important in helping the medical and physical therapy staff care for your athlete.**
3) **Ages:**
    a. Regular ImPACT is for ages 12+
    b. Pediatric ImPACT is for ages 5-11

Costs:

1) **BASELINE:** Mitchell County Regional Health Center offers baseline tests for **FREE!**
2) **POST-TEST:** Billed to your insurance, coverage is dependent on each individual plan.

If you have an athlete in 7th grade or above and they haven't had a BASELINE test yet, please call the Physical Therapy and Sports Rehab department at 641-732-6047 to schedule one. Also, feel free to call with any questions.

A FACT SHEET FOR PARENTS AND STUDENTS

HEADS UP: Concussion in High School Sports

Please note this important information based on Iowa Code Section 280.13C, Brain Injury Policies:

(1) A student participating in extracurricular interscholastic activities, in grades seven through twelve, **must be immediately removed from participation** if the coach, contest official, licensed healthcare provider or emergency medical care provide believe the student has a concussion based on observed signs, symptoms, or behaviors.

(2) Once removed from participation for a suspected concussion, the **student cannot return to participation until written medical clearance has been provided** by a licensed health care provider.

(3) A student cannot return to participation until s/he is free from concussion symptoms at home and at school.

(4) Definitions:

"Contest official" means a referee, umpire, judge, or other official in an athletic contest who is registered with the Iowa high school athletic association or the Iowa girls high school athletic union.

"Licensed health care provider" means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.

"Extracurricular interscholastic activity" means any extracurricular interscholastic activity means any dance or cheerleading activity or extracurricular interscholastic activity, contest, or practice governed by the Iowa high school athletic association or the Iowa girls high school athletic union that is a contact or limited contact activity as identified by the American academy of pediatrics.

"Medical clearance" means written clearance from a licensed health care provider releasing the student following a concussion or other brain injury to return to or commence participation in any extracurricular interscholastic activity.

What is a concussion?

Concussions are a type of brain injury that disrupt the way the brain normally works. Concussions can occur in any sport or recreational activity and can result from a fall or from players colliding with each other, the ground, or obstacles. Concussions can occur with or without loss of consciousness, but most concussions occur without loss of consciousness.

What parents/guardians should do if they think their child has a concussion?

1. Teach your child that it's not smart to play with a concussion.
2. **OBEY THE LAW.**
   a. Seek medical attention right away.
   b. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
3. Tell all of your child's coaches, teachers, and school nurse about ANY concussion.

What are the signs and symptoms of concussion?

Signs and symptoms of concussion can show up right after the injury or may not be noticed until days after the injury. If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be removed from play immediately. The athlete should only return to play with permission from a health care provider and after s/he is symptom free at home and at school.

Signs Observed by Parents or Coaches:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Symptoms Reported by Student-Athlete:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

STUDENTS, If you think you have a concussion:

- **Tell your coaches & parents –** Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up –** A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal –** If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

PARENTS/GUARDIANS, You can help your child prevent a concussion:

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

For more information visit: **www.cdc.gov/Concussion**

IMPORTANT: Students (grades 7-12) participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must annually sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.

We have received the information provided on the concussion fact sheet titled, "HEADS UP: Concussion in High School Sports."

Student's Signature _____ Date _____ Student's Printed Name _____

Parent's/Guardian's Signature _____ Date _____ Student's Grade _____ Student's School _____

Developed by IDPH, IHSAA & IGHSAU 1118

RELEASE OF INFORMATION: I agree that Mitchell County Regional Health Center and the people who work at Mitchell County Regional Health Center are authorized to release information from financial and/or medical records, even if the information is related to drug, alcoholism, or psychiatric care, to any person or organization which is responsible or who Mitchell County Regional Health Center reasonably thinks may be responsible for payment of bills. I understand that Mitchell County Regional Health Center may record my information in an electronic health record. I consent to the sharing of this information for patient care, payment, patient safety and quality of care purposes by hospitals and clinics that participate in the Mercy Health Network-North Iowa.

I agree my information can be shared by the hospital with other past, future and current providers, caregivers and facilities to coordinate my health care, for payment and for administrative purposes, including quality and care management. This information may include dates and services provided, location where treatment was received, treatment information, names of doctors and health professionals, including mental health professionals, and any information related to diagnosis, hospital care, or treatment of my mental or emotional condition, except for substance abuse treatment provided in a federal Part 2 substance abuse unit.

PERMIT FOR TREATMENT: This is my request and consent to treatment at Mitchell County Regional Health Center and to permit the attending provider, and other providers who may be consulted regarding my care and treatment; and the nurses, technicians and other persons who work at Mitchell County Regional Health Center to provide me with necessary care and services. This may include treatment, tests and other procedures and routine nursing care.

AGREEMENT: FINANCIAL

PRIVATE PAY: I understand I am financially responsible to Mitchell County Regional Health Center for charges not paid by insurance. I understand this amount is due upon billing.

CONTACT BY TELEPHONE AND/OR EMAIL: I agree to receive telephone calls, Short Message Service ("SMS") text messages, or other messages made or delivered to the telephone number(s) I have provided. I understand these calls or messages may be made or delivered using an automatic dialing system, pre-recorded voice, hospital employee, or hospital business associate for purposes of treatment, payment, and health care operations. If I give a cell phone number, I understand my cell phone company may charge me. If I have provided an email address, I agree the Hospital may use the email address I have provided to send me information for treatment, payment, or health care operations, including appointment reminders.

PHYSICIAN AND PROFESSIONA L FEES: I understand that I will receive separate bills from individual physicians and professional service organizations for any services performed.

ASSIG NMENT OF BENEFITS: I hereby assign to Mitchell County Regional Health Center the benefits due me from my insurance company.

PHYSICIAN AVAILABILITY: Mitchell County Regional Health Center does not have a MD/DO on the premises 24 hours per day, seven days per week. Ifan emergency medical condition develops, a physician is on call and readily available to come to the facility to meet your medical needs.

RIGHTS AND RESPONSIBILITIES: Mitchell County Regional Health Center Patient Rights and Responsibilities, Visitor Rights and Advance Directive For Healthcare information were made available to me

I have read this form (or have had it read to me) and understand it. I agree by signing thisform I am bound by what it says, whether I am the patient or someone acting the patient's behalf.

Patient/Guardian/Guarantor Signature	Witness
Relationship	Date

MCRHC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

MCRHC cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

MITCHELL COUNTY REGIONAL HEALTH CENTER

An Affiliate of MERCYONE