THE HEALTH & WELLNESS CENTER

Dear Parent/Guardian:

Welcome to the Health & Wellness Center at Centennial High School. For your student to receive a Sports Physical, please:

1. Call 970.488.4950 to schedule an appointment (no walk-ins please)
2. Available Days/Times: Beginning the week of July 12th, Sports Physicals will be offered at Centennial High School on Tuesdays, Thursdays and Fridays between the hours of 8:30 - 5:00.
3. Complete the attached forms. Mail them to: The Health and Wellness Center at Centennial, 330 E. Laurel Street, Fort Collins, CO 80524 OR send an encrypted email to hwcenter@everychildpediatrics.org (to encrypt place [e] in the subject line) OR drop off at Centennial's Health office (room 205) OR arrive 15 minutes early to your scheduled appointment time and bring forms with you.
4. Payment: Cash pay for a Sports Physical is $40. We also offer a $0-$35 sliding scale (for qualifying families). We accept Medicaid/CHP+, most insurance plans and offer fee-for-service No co-pays/deductibles required. No student enrolled for care is ever turned away for an inability to pay for services offered at the Center.

5. Any PSD student may be enrolled and receive care and we prioritize meeting the needs of students/families who have barriers to accessing care.

We Create Healthy Learners Better Prepared for Academic and Life Success!

THE HEALTH & WELLNESS CENTER

HEALTH AND WELLNESS CENTER at CENTENNIAL HIGH SCHOOL
REGISTRATION FORM 2021+

1. STUDENT INFORMATION

Date:	Last Name:	First Name:
Middle Name:	Date of Birth:	Sex: M ☐ F ☐ Other ☐
Grade:	School:	
Mailing Address:		
City:	State:	Zip Code:
Cell Phone:	Email:	
Please circle the category that most accurately represents the student's background: American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Multi/Other/Undetermined ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Do not wish to answer ☐		
Does the student consider him/herself Hispanic/Latino? ☐ Yes ☐ No If Bilingual, please list the languages spoken:		

2. FAMILY INFORMATION (Please Print)

Parent/Guardian, Last and First Name:		
Relationship:	Cell phone #:	Work phone #:
Email:		
Mailing Address:		
City:	State:	Zip Code:

Parent/Guardian, Last and First Name:		
Relationship:	Cell phone #:	Work phone #:
Email:		
Mailing Address:		
City:	State:	Zip Code:

3. Preferred Method to receive communication (Please Check all that apply) Phone ☐ Text ☐ Email ☐ US Mail ☐

CONTINUED – SEE NEXT PAGE

Office Use Only
Intl:
Date:

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4. EMERGENCY CONTACT (if we are unable to reach the parents/guardians listed above)

1. Name:	Relationship:	Cell:	Work:
2.Name:	Relationship:	Cell:	Work:

5. HEALTH INSURANCE INFORMATION: ***Please bring insurance card or a copy of both sides to your appointment.***

Check all that apply

Medicaid -

Primary Insured Name: ID #: Group #:

CHP+ -

Primary Insured Name: ID #: Group #:

Private Insurance - Name of Company:

Primary Insured Name: ID #: Group #:

No Insurance

Number of people who live in your household:
What is your family's gross total yearly income (before taxes): $ /year

I confirm that my student does not have health insurance that will cover services s/he is receiving and to the best of my knowledge, the family financial information listed above is complete and correct. _____

Signature of Parent/Guardian (or Student if 18+)

If necessary, may we contact you regarding health insurance information? ☐ Yes ☐ No

How did you hear about the Center? (Please Check all that apply):

Poster ☐ Flyer ☐ PSD Website ☐ School Newsletter ☐
School Website ☐ Word of Mouth ☐ Back to School Night ☐
School Referral from: ☐ Teacher ☐ Coach ☐ Athletic Director ☐ Counselor ☐ Office Staff ☐
Other: _____

THE HEALTH AND WELLNESS CENTER AT CENTENNIAL HIGH SCHOL AND EVERY CHILD PEDIATRICS
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION 2021+

This office is permitted by federal privacy laws to make uses and disclosures of your protected health information for the purposes of treatment, payment and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

TREATMENT: We will use and disclose your protected information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, if during the course of your treatment, the licensed healthcare provider determines he/she will need to consult with a specialist, he/she will share the information with such specialist and obtain his/her input.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for health care services provided to you. If the health insurance company requests information from us regarding your care, we will provide that information to them.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your licensed healthcare provider practice. We obtain services from our insurers or other business associates, such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services and insurance. We will share information about you with such business associates as necessary to obtain these services; school nurse, school health paraprofessional, licensed staff to assure children attend school in a healthy state.

We may use or disclose, as needed your protected health information in the following situations without your authorization. These situations include: as Required By Law, Communicable Disease, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have the following rights:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your licensed healthcare provider is not required to agree to a restriction that you may request. If your licensed healthcare provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

CONTINUED – SEE NEXT PAGE.

THE HEALTH AND WELLNESS CENTER AT CENTENNIAL HIGH SCHOL AND EVERY CHILD PEDIATRICS
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION 2021+

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your licensed healthcare provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected information. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or by phone at our main number, below.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Today's Date _____

_____ _____

Printed Name of Student **Student's Date of Birth (MM/DD/YY)**

_____ _____

Printed Name of Parent/Guardian (or Student if 18+) ***Signature of Parent/Guardian (or Student if 18+)***

Patient Notification of the Use of Health Information Exchange

Every Child Pediatrics (ECP) endorses, supports and participates in the electronic Health Information Exchange (HIE) as a means to improve the quality of patient's health and healthcare experience. HIE provides ECP with a way to securely and efficiently share your student's clinical information electronically with other healthcare providers that participate in the HIE network. Using HIE helps your student's health care providers to more effectively share information and provide your student with better care. The HIE also enables emergency personnel and other providers who are treating your student to have immediate access to their medical data that may be critical for their care. Making your student's health information available to their health care providers through the HIE can also reduce costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt out of, on behalf of your student, participation in the Every Child Pediatrics HIE, or cancel an opt-out choice at any time.

THE HEALTH & WELLNESS CENTER

HEALTH AND WELLNESS CENTER at CENTENNIAL HIGH SCHOOL
CONSENT TO MEDICAL TREATMENT 2021+

Instructions: INITIAL all statements, fill in information as requested and sign at the bottom

_____ I understand that medical services at the Health and Wellness Center at Centennial High School (the "Center") are provided by Every Child Pediatrics (ECP). I give permission for the Center to provide any of the physical health and mental health care services listed below to my student during his/her enrollment in the Center, when advised or recommended by the Center staff:

Student health electronic questionnaire, (including medical & mental health questions)
Well child check / sports physical
Routine lab tests
Treatment of minor illness and injury
Management of chronic illness
Referrals to community agencies for other necessary care

_____ I understand that the Center does NOT offer certain services, including but not limited to, the following:

Hospitalization
Emergency Care (except as required by law)
Pharmacy services
Restorative dental care
Sutures / Casting
Treatment of complex medical or psychiatric conditions
X-Rays
Dental fillings or extractions

_____ I have read above and understand the services offered by the Health and Wellness Center at Centennial High School and am requesting said services be provided to my student.

_____ I understand that the Center may serve as my student-patients primary care physician (PCP) and/or may collaborate with a PCP of my choosing and with my consent to release information.

_____ I understand that the Center maintains electronic medical records. I authorize electronic downloading of eligibility and medication history information.

_____ I understand that the Center staff will attempt to notify me about my student's encounter with the medical professional as deemed appropriate by the provider. I understand, that by law, in some instances students can access care independently and confidentially.

_____ I understand that this consent includes consent for referral of care and, if needed, to summon emergency services (911), emergency transportation to other physicians, health care professionals, hospitals, clinics or health care agencies as deemed necessary by the Center's staff. Expenses related to ambulance or other emergency referral will be my responsibility. Nothing in this authorization shall be deemed to modify or limit the responsibility and authority of the Center or Poudre School District to deal with emergency medical situations as is appropriate.

_____ I will attempt to make myself available for communication regarding my student's health needs. I understand that there are certain hazards and risks connected with all forms of treatment and consent is given in light of this knowledge. I understand it is my duty to inform the Center staff of any change in my student's guardianship.

CONTINUED – SEE NEXT PAGE.

_____ I consent for the Center staff to access my student's immunization and other school related records that may assist the staff in helping my child.

_____ I have received/read the Center and ECP's Notice of Privacy Practices for Protected Health Information.

_____ I understand that all information in my student's medical record is confidential and will not be released to any unauthorized person or agency without written consent. This practice conforms to Colorado law.

_____ I authorize the Center to share or disclose all or any portion of my child's medical record to any entity pertinent to his/her healthcare, including but not limited to ECP, the Center staff, the student's primary care provider, and the home school (**insert school name**):_____health technician, nurse, counseling staff, coaching or administrative staff of student's**. *If there are specific roles I do NOT want information shared on the list above, I have crossed them off.***

_____ I understand that the Center may share or be required to share my student's health care information with certain persons or agencies for purposed treatment, health care operations, billing and payment or as otherwise required by law, without having to ask my permission or needing a signed authorization.

_____ I understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for health services I receive at this school based health center and is legally able to receive information regarding services provided to patients. CDPHE receives combined data for all patients and this data does not specifically identify any individual patient.

_____ I understand the Center is open limited hours (generally during school hours/days Monday – Thursday) and is closed, for example at night, on weekends and for school holidays. During clinic closures I may call ECP Thornton office at 1-303-450-3690 to reach the on-call provider or nurse line. If experiencing an emergency, I will take my student to the nearest emergency room or call 911 immediately.

_____ I understand that the Center needs to cover its expenses. I will provide my insurance information and I give permission for the Center/ECP to bill my student's applicable health insurer for services received. If I do not have insurance, I agree to discuss my family's eligibility for available public insurance programs or sliding fee scale options with the Center.

_____ I understand that this consent form remains valid for the length of three years from the date of consent indicated below and/or while the student is enrolled with Poudre School District.

_____ I understand I may withdraw this consent at any time by providing written notice to the Center's Health and Wellness Coordinator at the Health and Wellness Center at Centennial High School, 330 East Laurel Street, Fort Collins, CO 80524. This is called revocation. I understand that once written notice is received, the Center will stop sharing information from that point on, but that revocation does not apply to any information the Center has already released.

Agreement: By signing below I acknowledge that I have read and understand the above provisions and certify that I am legally authorized to provide this consent for services.

I am enrolling this student in the Health and Wellness Center at Centennial High School **Yes** ☐ **No** ☐

_____ _____

Printed Name of Student **Date**

_____ _____

Printed Name of Parent/Guardian (or Student if 18+) ***Signature of Parent/Guardian (or Student if 18+)***

THIS FORM IS ONLY REQUIRED FOR SPORTS PHYSICALS/ WELL CHILD EXAMS ONLY

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. 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)?		
14. 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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____