THE HEALTH & WELLNESS CENTER

Please Keep This Page for Your Information

Dear Parent/Guardian:

Welcome to the Health and Wellness Centers at Centennial High & Lincoln Middle Schools. Attached your will find a packet of forms to enroll and consent for your student's care. Medical and/or mental health services are available in-person AND through virtual care. **To enroll, please complete the the medical, mental health, and virtual care enrollment and consent forms.** All Poudre School District students who enroll in the Center may use the services, but parental consent is required for most services. Please note, Colorado law allows minors to self consent for some services including, but not limited to reproductive health care at any age and mental health services as of 12+ years of age.

- **Appointments can be made by calling 970.488.4900**
- Any PSD student may enroll and receive care
- We never turn a student away for inability to pay or for not having insurance
- ***Our goal is to Create Healthy Learners Better Prepared for Academic and Life Success!***

Like other medical and mental health providers, the Health and Wellness Center can and does bill most insurance, (including Medicaid and CHP+).

If you have health insurance:

- No copay is collected, due to a special accommodation allowed by the state of Colorado only for School Based Health Centers.
- Please be sure to provide your insurance information or complete the "income attestation for sliding scale services" so that you do not receive a bill for the full amount.
- If you receive billing statements, they will be from Every Child Pediatrics in Thornton, CO.

If you are NOT currently insured:

- The Center offers a sliding fee scale. Please complete the section entitled "income attestation for sliding scale services" on the back of the Registration Form. We will contact you regarding the scale.
- We are also a certified Medicaid enrollment assistance site and can assist in enrollment for this program with students/families that do not have health insurance.

Checklist:

- ☐ A parent or guardian must sign all of the forms if the student is under 18 years of age; students 18 and older sign their own forms.
- ☐ Forms can be: **mailed to** The Health and Wellness Center at Centennial, 330 E. Laurel Street, Fort Collins, CO 80524 **OR emailed** to **hwcenter@everychildpediatrics.org** **OR dropped off** at Centennial's Health office (room 205) **OR dropped off** at the Lincoln Health Office (room 514).
- ☐ If you have insurance (including Medicaid/CHP+), please copy the front and back of your card and return the copies with the packet.
- ☐ Please stop by the Center, call 970-488-4900 or email hwcenter@everychildpediatrics.org with questions.

THE HEALTH & WELLNESS CENTER

HEALTH AND WELLNESS CENTER at CENTENNIAL HIGH SCHOOL
REGISTRATION FORM 2022+

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:

THE HEALTH & WELLNESS CENTER

HEALTH AND WELLNESS CENTER at CENTENNIAL HIGH SCHOOL
REGISTRATION FORM 2022+

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 & WELLNESS CENTER

THE HEALTH AND WELLNESS CENTER AT CENTENNIAL
HIGH SCHOOL STUDENT MEDICAL HISTORY 2022+
PLEASE PRINT

Student Last Name:	First Name:	Date of Birth (mm/dd/yy):
Primary Care Dr./Practice:	Phone:	Pharmacy:
Last complete/sports/ physical date:		

MEDICATIONS
Is the student currently taking medications: Yes ☐ No ☐ *If Yes, please fill out this table*

MEDICATION NAME/DOSAGE/WHEN TAKEN	REASON FOR MEDICATION

ALLERGIES
Does the student have any allergies: Yes ☐ No ☐ *If Yes, please fill out this table:*

Medication allergies: Yes ☐ No ☐ *If Yes, please list any medication and allergic reaction*:	
Medication	*Reaction*
Medication	*Reaction*
Other allergies: Yes ☐ No ☐ *If Yes, please describe:*	

PAST MEDICAL HISTORY
(check any conditions that the student currently has, or has had in the past, and please describe below)

Autism ☐	Eating disorders ☐	Migraine headaches ☐	Skin problems ☐
Anemia ☐	Fainting with exercise ☐	Missing an organ ☐	Stomach/intestinal problems ☐
Asthma ☐	Head injury/concussion ☐	Mono (within past month) ☐	Stroke ☐
Cancer/Type_____	Heart problems ☐	Obesity ☐	Surgeries/Type_____
Chest pain with exercise ☐	High blood pressure ☐	Pregnancy ☐	Thyroid problems ☐
Diabetes ☐	Kidney problems ☐	Seizures ☐	
Drug or alcohol addiction ☐	Liver problems ☐	Sickle cell disease/trait ☐	

Other concerns not listed: Yes No If Yes, explain _____

Explain any conditions circled above _____

CONTINUED – SEE NEXT PAGE

THE HEALTH & WELLNESS CENTER

THE HEALTH AND WELLNESS CENTER AT CENTENNIAL HIGH SCHOOL STUDENT MEDICAL HISTORY 2022+

PLEASE PRINT

MENTAL HEALTH HISTORY

Student has a history of mental health diagnosis: Yes ☐ No ☐ *If Yes, please fill out this table:*

Diagnosis:	Name of counselor:	Psychiatrist:
Other important mental health history:		

PAST HOSPITALIZATIONS

Has the student ever had to stay in the hospital: Yes ☐ No ☐ *If Yes, please explain:*

_____

_____

FAMILY HEALTH HISTORY (check any conditions affecting immediate family members and describe below)

Anemia	☐ Depression/Anxiety	☐ Kidney disease	☐ Seizures	☐
Bipolar disorder	☐ Diabetes	☐ Liver disease	☐ Stroke	☐
Blood Clotting disorders	☐ Drug/Alcohol addiction	☐ Lung disease	☐ Sudden death	☐
Breast cancer	☐ Heart Disease	☐ Migraine headaches	☐ Suicide	☐
Cancer; Type _____	☐ Heart attack under 50	☐ Obesity	☐ Thyroid problems	☐
		☐ Schizophrenia	☐ Other: _____	☐

Describe any checked responses:

I understand that if there are important changes to the medical history of the student or the medical history of the student's family that Health and Wellness Center will be notified directly by calling 970-488-4950 or notifying the provider in person. This is to ensure that the student is provided with the highest quality health care possible.

_____ _____ _____

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

THE HEALTH AND WELLNESS CENTER AT CENTENNIAL HIGH SCHOL AND EVERY CHILD PEDIATRICS
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION 2022+

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 2022+

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 2022+

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+)***

THE HEALTH & WELLNESS CENTER

The Health and Wellness Center at Centennial High School
Mental-health Services Disclosure Form and Release of Mental Health Information 2022+

This document outlines the services and policies of the Health and Wellness Center at Centennial High School's (H&WC@CHS) mental health services. These services are provided by Licensed Behavioral Health Professionals (LBHPs), the qualifications for whom are provided at the time of service.

Please read and ask for clarification on anything you do not understand. This form will be signed and kept on file in the H&WC@CHS (on site) or at the Lincoln Middle School Telehealth Program site. You may also request a copy.

GENERAL INFORMATION: You are entitled to receive information about methods of treatment, the expected length of treatment and the limitations of receiving mental health treatment within a school-based health center. You may seek a second opinion from another therapist. Please be advised that there are no guaranteed results from therapy. Also, you may terminate therapy at any time.

Sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board (DORA). The Colorado Department of Regulatory Agencies (DORA) regulates the practices of licensed and unlicensed psychotherapists. The Mental Health Section is located at, 1560 Broadway, Suite 1370, Denver, CO 80202; (303) 894-7766.

CONFIDENTIALITY: Any information, written or verbal, regarding the services you receive from H&WC@CHS LBHPs will be kept confidential to the extent required by law. General mental health records, *other than psychotherapy notes*, may be used and disclosed by a provider for your treatment, referral, for billing and for other reasons permitted by law. General mental health records includes medication prescription and monitoring, counseling session start and stop times, the methods and frequency of your treatment, clinical test results, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. However, H&WC@CHS LBHPs will not disclose psychotherapy notes regarding your treatment without written authorization, or as permitted by law. Psychotherapy notes are notes for documentation or analysis of assessments, interactions, groups and or individual therapy sessions. There are a few very limited instances when the LBHP is legally and ethically bound to disclose psychotherapy notes regarding your treatment, such as:

- If there is reason to believe, in good faith, that disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another person
- If child or elder abuse or neglect has occurred or is occurring, or there is reasonable cause to believe has occurred
- If ordered by a court of law
- Disability applications (if requested by authorizing agency)

For any other reasons not required or permitted by law, your prior written authorization is required before disclosing psychotherapy notes regarding your treatment.

CONTINUED – SEE NEXT PAGE.

THE HEALTH & WELLNESS CENTER

The Health and Wellness Center at Centennial High School Mental-health Services Disclosure Form and Release of Mental Health Information 2022+

Periodically, LBHPs may share or exchange information with medical and professional staff within the H&WC@CHS as well as with designated school staff.
I understand I can revoke this privileged communication in writing at any time.

This consent for services is authorized for the length of the school year and/or while the student is enrolled at Centennial High School or at Lincoln Middle school.
I may withdraw this consent at any time with written notice to the H&WC@CHS.

AVAILABILITY: Generally, there is a LBHP available during school hours. Voicemails at (970) 488-4961 are checked and responded to during those hours. If immediate assistance is needed, please call either 911 or Poudre Valley Hospital at (970) 495-7000.

AGREEMENT: By signing below I acknowledge that I have read and understand the above sections. I certify that I am legally authorized to provide this consent, and that I may request a copy of this disclosure statement for my records at any time.

Student 12 yrs of age or older PRINTED Name	**Student 12 yrs of age or older Signature**	**Date**
OR Parent/Guardian (student under 12) PRINTED Name	**Parent/Guardian Signature**	**Date**
Therapist PRINTED Name	**Therapist Signature**	**Date**

Telehealth Consent to Treat 2022+

THE HEALTH & WELLNESS CENTER

Student Name:_____Date of Birth: _____

I give my permission for the Health and Wellness Center at Centennial High School, School-Based Health Center (SBHC), to provide health care to the student named above. In addition to onsite care at the Health and Wellness Center at Centennial, this clinic also provides medical and mental health care via telehealth.

Telehealth Consent

1. I understand that telehealth is the exchange of medical and/or mental health information from one site to another by electronic communications. This may include physical exams and counseling services using two-way HIPAA compliant audio/video and other forms of technology.

2. I understand that the Health Care Provider and my child will not be in the same room but that an Every Child Pediatrics' staff member, called a Telehealth Presenter, will be in the room with my child or in a total virtual care model, all participants will be accessing services remotely and independently.

3. I understand all applicable confidentiality protections shall apply to the services. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others, a medical emergency occurring while on telehealth call).

4. I understand that Every Child Pediatrics' (SBHC) Program staff may share appropriate health information with school Health/Counseling/Administrative staff to support coordination of care for students with medical and/or mental health needs.

5. I understand that I retain the option to refuse the delivery of health care services via telehealth at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

6. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

Emergency Protocols for Virtual Online Teleservices

7. I understand that my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

8. Your provider requires knowledge of your location in case of an emergency. You agree to provide an address where you are at the beginning of each session and a contact person who may be contacted on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. My emergency contact's name, relationship to me, address and phone are:
   _____

11. If accessing behavioral health services, I understand my provider will review the emergency protocol at the beginning of each session.

12. By initialing below, I agree that I have received an explanation of how the video/audio technology will be used to conduct telehealth healthcare. I understand there are limitations to the technology and the process of telehealth, including the potential for incomplete exchange or loss of information. I have received and understand the written information provided above.

I consent to use of telehealth for consultation, evaluation, diagnosis and treatment. _____ (Initial please)

By signing this form, I certify:

I have read this form (or have had this form read and/or had this form explained to me) and have been given ample opportunity to have my questions answered and my questions have been answered to my satisfaction and that I fully understand its contents including the risks and benefits of the procedure(s).

I understand that I may revoke my consent at any time. A request to revoke consent must be in writing and received by the Health and Wellness Center at Centennial High School SBHC.

I hereby voluntarily and freely agree and give my consent for treatment and to any related evaluation, assessment, and diagnosis as the health care provider deems appropriate for my student's current medical and/or mental health needs.

_____	_____	_____
Patient Printed Name	**Patient Signature**	**Date**

Parent/Guardian Signature (if required): _____

Read/reviewed consent with parent and/or patient (please circle) and obtained verbal consent due to CoVid-19:

_____	_____	_____
Staff Printed Name	**Staff Signature**	**Date**

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations.

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

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

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

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

_____

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

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

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

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed 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 age 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 (CPVT)?		
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?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____