MITCHELL COUNTY REGIONAL HEALTH CENTER

An Affiliate of MERCYONE

2025 Forms Packet
Student-Athlete Physicals/ImPACT Testing

- Please call **641-732-6100** to schedule an appointment in Osage and Riceville.
- To schedule an appointment in St. Ansgar call **641-736-4401**.
- Please bring insurance cards to the appointment or, if not using insurance $87.35.

All clinics offer the following choices:

Physical and ImPACT Testing together
Physical Only
ImPACT Testing Only

For the safety of patients and staff, all will be screened for COVID-19 at the clinic entrance. Please wear a facemask; we will provide one if needed.

Vaccine Consent Form: Recommended vaccines are listed. **PARENTS** – please initial and sign the form for any vaccines you would like your child to receive. We will verify the day of the physical which immunizations are needed. No vaccines will be given without your written consent.

Reminder: All students enrolling in 7th grade are required to have a TDAP (tetanus, diptheria and pertussis) and meningococcal (A,C,W,Y) vaccines. Students enrolling in 12th grade are required to have two doses of meningococcal (A,C,W,Y) vaccine if born after September 15, 1999 or 1 dose if received when age 16 or older.

ImPACT/Concussion Baseline Testing: Recommended every two years as a baseline test for all athletes. The baseline test is **free** and can usually be scheduled at the same time as the physical. This test helps determine a return-to-activity time should a head injury occur.

Iowa Athletic Pre-Participation Form: Complete Health History section prior to appointment.

Consent to Treat: to be signed if parent is not accompanying the student to the appointment.

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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:_____

August 12, 2022

Dear Physicians, Athletic Directors and School Medical Personnel:

The Committee on Sports Medicine of the Iowa Medical Society is updating the Pre-Participation Physical Evaluation (PPE) form starting the 2022-2023 sports seasons. This updated form was revised and created for the participants in Iowa High School Athletics in order to be most current in best practices of screening and identifying health concerns of the student athlete that are relevant to their safe participation. The information used for this update was from the Pre-Participation Physical Evaluation, 5th Edition, published in 2019. The updated form and plans for transition were shared with the Iowa Association of School Boards for review and input prior to dissemination.

Below are some brief highlights of changes to the attached form:

- Expanded Format-The form is now 4 pages instead of 2 pages.
- Mental Health Screening
- Expanded Adolescent Safety Questions
- Updated Health Questions and Physical Examination
- Confidentiality and Format Changes

SPECIAL NOTE: **Page 4 of this form is ALWAYS turned in to the school for participation/clearance and emergency contact information**. This page can be used by any and all personnel of the school.

However, due to HIPAA/FERPA regulations, a licensed health care professional and confidential storage of the sports physical form pages 1 through 3 is necessary, if those pages are to be kept at the school and used for medical purposes. Otherwise, pages 1 through 3 can be kept with the provider who performs the Pre-participation Examination and a waiver should be signed for release of information by the student athlete and parent if this is required by the school for participation of the student athlete. (*Ref: 5th Edition of Pre-Participation Physical Examination, 2019, pgs 25-27)*

We appreciate your understanding in these updates and changes to mirror best practices in the Pre-Participation Examination. By working together in this, we can help to provide the safest environment for participation of our student athletes.

IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

Please complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of Birth: _____

Date of Examination: _____ Sport(s): _____

Home Address (Street, City, Zip): _____ School District: _____

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

Physician: _____ Phone #: _____

History Form:

List past and current medical conditions.

_____

Have you ever had a 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 (to medicines, pollen, food, stinging insects, etc.)

_____

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 Everyday
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)

SCORE: _____

In the section below, if you answer "yes" to any questions, please explain further in the space provided at the end of this form. Circle any questions you don't know the answer to.

General Questions:

Y N

- ˜°Do you have any concerns that you would like to discuss with your provider?
- ˜°Has a provider ever denied or restricted your participation in sport for any reason?
- ˜°Do you have any ongoing medical issues or recent illnesses?

Heart Health Questions:

Y N

˜° ˜°Have you ever passed out of 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, flutter in your chest or skip beats (irregular beats) during exercise?

˜° ˜°Has a doctor ever told you that you have any heart problems?

˜° ˜°Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?

˜° ˜°Do you get lightheaded or feel shorter of breath than your friends during exercise?

˜°Do you have high blood pressure or high cholesterol? IOWA

Questions about your Family:

Y N

- ˜°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)?
- ˜°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)?
- ˜°Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?
- ˜°Does anyone in your family have asthma?

Bone and Joint Questions:

Y N

- ˜°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?
- ˜°Have you had an X-ray, MRI, CT scan or physical therapy for any reason?
- ˜°Do you have a bone, muscle, ligament or joint injury that bothers you?
- ˜°Do you currently, or have you in the past worn orthotics, braces or protective equipment for any reason?

Medical Question:

Y N

- ˜°Do you cough, wheeze or have difficulty breathing during or after exercise?
- ˜°Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?
- ˜°Do you have groin or testicle pain or a painful bulge or hernia in the groin area?
- ˜°Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?
- ˜°Have you had a concussion? Or a head injury that caused confusion, a prolonged headache, or memory problems?
- ˜°Have you ever had a seizure?
- ˜°Do you get frequent headaches?
- ˜°Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?
- ˜°Have you ever become ill when exercising in the heat?
- ˜°Do you have sickle cell trait or disease? Or anyone in your family?
- ˜°Have you ever had or do you have any problems with your eyes or vision?
- ˜°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 or food groups?
- ˜°Have you ever had an eating disorder?

FEMALES only:

Y N

- ˜°Have you ever had a menstrual period?
- ˜°How old were you when you had your first menstrual period?
- ˜°When was your most recent menstrual period?
- ˜°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 questions on this form are complete and correct.

Signature of Athlete: _____

Signature of Parent or Guardian: _____ Date: _____

Physical Examination *(To be filled out by medical provider)*

Consider additional questions as below:

Y N

- ˜°Do you feel stressed out or under a lot of pressure?
- ˜°Do you ever feel sad, hopeless, depressed or anxious?
- ˜°Do you feel safe at your home or residence?
- ˜°Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?
- ˜°Do you drink alcohol or use any other drugs?
- ˜°Have you taken prescriptions medications that were not yours or outside of their intended use?
- ˜°Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
- ˜°Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- ˜°Do you wear a seat belt and a helmet?
- ˜°Do you use condoms if you are sexually active?

EXAMINATION

Height: _____ Weight: ————————

BP: _____ / _____ (____ / ____) Pulse: _____ Vision: R 20/____ L 20/ ____ Corrected Y / N

MEDICAL	**NORMAL**	**BNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)	**A**	
Eyes, ears, nose and throat • Pupils equal & Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and ± Valsalva)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus, lesions suggestive of MRSA or Tinea Corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**BNORMAL FINDINGS**
Neck	**A**	
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, hand, and fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional · May include: Duck Walk, Double-leg squat test, single-leg squat test, and box drop or step drop test		

· Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings or a combination of those.

Medical Eligibility Form

Student Athlete Name: _____ Date of Birth:_____ Date of Examination: _____

I acknowledge and give consent for a copy of this entire form to be kept in the student's school record. I agree that should student's health change in any way that would alter this form that I will inform the school as soon as possible.

Signature of Parent or Guardian: _____ Date: _____

Shared Emergency Information *(To be filled out by athlete/athlete's caregiver)*

Allergies:
_____

Medications:
_____

Other Information:
_____

Emergency Contacts:

Name	Relationship	Contact Information
_____	_____	_____
_____	_____	_____

Participation Eligibility *(To be filled out by medical provider)*

~° Medically Eligible for sports without restriction.

~° Medically Eligible for all sports without restriction with recommendations for further evaluation or treatment of:
_____

~° Medically eligible for certain sports:
_____

~° Not medically eligible pending further evaluation
_____

~° Not medically eligible for any sports
Recommendations:

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined in this form. A copy of the physical examination findings is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional:

_____

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 concussions sustained by our student-athletes, we use a software tool called ImPACT manage(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 be done anytime. It provides data on how your athlete's healthy brain performs. The BASELINE test is can 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 th grades (there is a pediatric test for younger ages). 11

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 physical therapy staff care for your athlete.**

helping the medical and 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 Scho

(1) ***Please note this important information based on Iowa Code Section 280.13C, Brain Injury Policies:*** 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, discapacidadMCRHC cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, o sexo.