

Affinia Healthcare School Based Medical team can provide medical services at your child's school. Your child's participation is voluntary. **In order for your child to receive these services; you must provide all information requested below. This consent is valid for one year.**

**Demographics**

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Sex:  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Zip: \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_  
 Parent/Guardian Name (please print): \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Cell Phone #: (\_\_\_\_) \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Language spoken at home: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone #: (\_\_\_\_) \_\_\_\_\_

**Ethnicity, Race, and Housing (For Statistic Purposes Only)**

Ethnicity:  Hispanic or Latino  Non Hispanic or Latino  
 Race:  American Indian or Alaskan Native  Asian  Black or African American  
 Native Hawaiian or Other Pacific Islander  White

Does your family participate in a Housing Assistance Program?  Yes  No  Decline to report  
 If yes, which type:  Public Housing  Section 8 Housing  Housing Voucher Program  Subsidized Housing  
 Other (please list type \_\_\_\_\_)

Does your family live in a Homeless Shelter or without housing at this time?  Yes  No  Decline to report

**Health History: Please check any history of/or difficulty with any of the following:**

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hearing Disorder	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear Infections (frequent)	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Back Problems/Scoliosis	<input type="checkbox"/> Ear Surgery	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Physical Problems
<input type="checkbox"/> Behavioral Issues	<input type="checkbox"/> Eczema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Eye/Vision Problems	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Lead Poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Headaches (frequent)	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> None of these listed

**Allergies, please describe type:**  Food \_\_\_\_\_  Latex \_\_\_\_\_  
 Medication \_\_\_\_\_  Seasonal \_\_\_\_\_  Other \_\_\_\_\_

**Describe type of reaction:** \_\_\_\_\_

Hospitalization date(s), please describe problem: \_\_\_\_\_

Surgery date(s), please list reason for surgery: \_\_\_\_\_

Please explain any item checked above: \_\_\_\_\_

Please list any medications your child is taking: \_\_\_\_\_

Any other concerns or comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Insurance**

Does your child have a **medical doctor**? Yes No If yes, when was the last time your child saw his/her doctor for a physical or well child exam? Provider/Clinic: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Preferred Pharmacy** (If M.D. or Nurse Practitioner feels your child would benefit from medications):  
Pharmacy Name: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child have **health insurance**? Yes No

**Missouri Medicaid/Mo Health Net** Yes No If yes, Plan or DCN # \_\_\_\_\_

**Other Medical Insurance** Yes No If yes, Plan Name and # \_\_\_\_\_

**Permission for Affinia School Based Services**

Medical Services: This may include completing pediatric comprehensive medical histories and/or physical examinations, sports physicals, immunizations (scheduled and CDC recommended age-appropriate vaccines will be administered), vision and hearing screenings, referrals for specialty care, diagnosing and treating acute and chronic medical problems, writing prescriptions for medications, lab testing and interpreting test results. In addition, a complete asthma check-up consisting of provider examination, spirometry, an asthma action plan, and completion of permission to carry/administer documentation for those students that qualify can be performed.

\* Physical exams may require a child to be partially unclothed during the exam. Parents are welcome to be present. Girls are encouraged to wear a bra or swim suit top

***\*Please note, this consent is valid for one year***

**I give permission for Affinia Healthcare School Based Team to provide services for my child. I verify, I have read the information regarding the notice of Privacy Practices (HIPAA).**

**I give consent for Affinia Healthcare to use and disclose my child's health information to people involved in my child's care, also including my child's regular doctor and school nurse.**

**I give consent for payment of authorized insurance carriers to be made on my behalf of Affinia Healthcare for any services furnished to my child.**

Parent/Legal Guardian Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Legal Guardian (signature):** \_\_\_\_\_ Date: \_\_\_\_\_

Provider Review (signature): \_\_\_\_\_ Date: \_\_\_\_\_

Support Staff Review (initial/date): \_\_\_\_/\_\_\_\_/\_\_\_\_

**Affinia Healthcare  
1717 Biddle Street  
St. Louis, MO 63106**

***Notice of Privacy Practices***  
**Written Acknowledgement Form**

***About Our Notice of Privacy Practices***

We are committed to protecting your personal health information in compliance with the law. Our *Notice of Privacy Practices* states:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your personal health information
- Our right to change our *Notice of Privacy Practices*
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures
- The person to contact for further information about our privacy practices

**I have been informed of Affinia Healthcare's *Notice of Privacy Practices*.  
I am aware that I have a right to receive a written copy of Affinia Healthcare's  
*Notice of Privacy Practices* upon request.**

**DOB:** \_\_\_\_\_

\_\_\_\_\_  
**Print: Full Name of Patient**

\_\_\_\_\_  
Medical Record #

\_\_\_\_\_  
**Signature of Patient/Guardian/Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print: Name of Guardian/Representative**

\_\_\_\_\_  
**Title/Relationship**

\_\_\_\_\_  
**Print: Witness**

\_\_\_\_\_  
**Title**

# Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

**For parents/guardians:** The following questions will help us determine which vaccines your child may be given today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the child have lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY \_\_\_\_\_

DATE \_\_\_\_\_

FORM REVIEWED BY \_\_\_\_\_

DATE \_\_\_\_\_

**Did you bring your immunization record card with you?**

yes  no

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

# MSHSAA PRE-PARTICIPATION DOCUMENTATION – ANNUAL REQUIREMENTS

## MEDICAL HISTORY

**Note: Complete and sign this form (with your parents if younger than 18) before your appointment. The physician should keep a copy of this form in the chart for their records.**  
**Note: An injury or medical condition results in a separate medical release.**

<b>Name:</b>	<b>Date of Birth:</b>
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Date of examination:

<b>Sex assigned at birth (F, M or intersex):</b>	<b>How do you identify your gender? (F, M or other):</b>
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**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 of your allergies (i.e., 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
<b>Feeling nervous, anxious or on edge:</b>	0	1	2	3
<b>Not being able to stop or control worrying:</b>	0	1	2	3
<b>Little interest or pleasure in doing things:</b>	0	1	2	3
<b>Feeling down, depressed or hopeless:</b>	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.**

Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.

GENERAL QUESTIONS	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 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 ordered a test for your heart? (For example, electrocardiography (ECG) or echocardiography?)		
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 (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 <i>Staphylococcus aureus</i> (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?		
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?		

IF "YES," EXPLAIN ANSWERS HERE

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

<b>Signature of Athlete:</b>
<b>Signature of Parent(s) or Guardian:</b>
<b>Date:</b>

**PARENT PERMISSION (Authorization for Treatment, Release of Medical Information, and Insurance Information)**

**Informed Consent:** By its nature, participation in interscholastic athletics includes risk of serious bodily injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS, OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN MSHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN/S SIGNATURE.**

I understand that in the case of injury or illness requiring transportation to a health care facility, a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be en route to or from another school or during practice or an interscholastic contest; and we hereby agree to hold the school district of which this school is a part and the MSHSAA, their employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

In the event of an emergency or when the Parent(s) or Guardian is unable to directly supervise health care services needed by the student for injuries or illnesses sustained at any athletic practice, conditioning exercise or contest, I also give my consent to the rendering of necessary health care services for the student by a qualified provider (QP) covering the athletic practice, conditioning exercise or contest, including an athletic trainer, physician, physician assistant, nurse practitioner or other medically-trained professional licensed by the State of Missouri (or the state in which the student injury or illness occurs) and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by state law. In emergency situations, the QP may also be a certified paramedic or emergency medical technician for the purpose of providing emergency health care and transport. Health care services are defined as services including, but not limited to, evaluation, diagnosis, first aid, emergency care, stabilization, treatment and referral. I further authorize the QP who provides such health care services to disclose such information about the student's injury or illness, diagnosis, care and treatment in the professional judgment of the QP to the student's athletic director, coaches, school nurse and any classroom teacher required to provide academic accommodation to assure the student's recovery and safe return to activity. If the Parent(s) or Guardian believes that the student is in need of further evaluation, treatment, rehabilitation or health care services for the injury or illness, the student may be treated by the physician or provider of his or her choice.

To enable the MSHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in the MSHSAA member school, I consent to the release of any and all portions of school record files to MSHSAA, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received, and attendance data.

We confirm that this application for the above student to represent his/her school in interscholastic athletics is made with the understanding that we have studied and understand the eligibility standards that our son/daughter must meet to represent his/her school and that he/she has not violated any of them. We also understand that if our son/daughter does not meet the citizenship standards set by the school or if he/she is ejected from an interscholastic contest because of an unsportsmanlike act, it could result in him/her not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I consent to the MSHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and we certify that it is correct and complete.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic health/accident insurance coverage, which includes athletics. Our son/daughter is covered by basic health/accident insurance for the current school year as indicated below:

<b>Name of Insurance Company:</b>	<b>Policy Number:</b>
<b>Signature of Parent(s) or Guardian:</b>	<b>Date:</b>
<b>Has this student incurred a medical condition since their last physical examination?</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

**STUDENT AGREEMENT (Regarding Conditions for Participation)**

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them.

I have read, understand, and acknowledge receipt of the MSHSAA brochure entitled "How to Maintain and Protect Your High School Eligibility," which contains a summary of the eligibility rules of the MSHSAA. (I understand that a copy of the *MSHSAA Handbook* is on file with the principal and athletic administrator and that I may review it in its entirety, if I so choose. All MSHSAA by-laws and regulations from the *Handbook* are also posted on the MSHSAA website at [www.mshsaa.org](http://www.mshsaa.org)).

I understand that a MSHSAA member school must adhere to all rules and regulations that pertain to school-sponsored, interscholastic athletics programs, and I acknowledge that local rules may be more stringent than MSHSAA rules.

I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I understand that if I drop a class, take course work through Post -Secondary Enrollment Option, Credit Flexibility, or other educational options, this action could affect compliance with MSHSAA academic standards and my eligibility.

I understand that participation in interscholastic athletics is a privilege and not a right. As a student athlete, I understand and accept the following responsibilities:

- I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
- I will be fully responsible for my own actions and the consequences of my actions.
- I will respect the property of others.
- I will respect and obey the rules of my school and laws of my community, state, and country.
- I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state, and country.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

<b>Signature of Athlete:</b>	<b>Date:</b>
<b>Have you experienced a medical condition since your last physical examination?</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

**PARENT AND STUDENT SIGNATURE (Concussion Materials)**

I accept responsibility for reporting all injuries and illnesses to my school and medical staff (athletic trainer/team physician) including any signs and symptoms of a CONCUSSION. I have received and read the MSHSAA materials on Concussions, which includes information on the definition of a concussion, symptoms of a concussion, what to do if I have a concussion and how to prevent a concussion. I will inform my school and athletic trainer/team physician immediately if I experience any of these symptoms or if I witness a teammate with these symptoms.

<b>Signature of Athlete:</b>	<b>Date:</b>
<b>Signature of Parent(s) or Guardian:</b>	<b>Date:</b>

**EMERGENCY CONTACT INFORMATION**

<b>Parent(s) or Guardian</b>	<b>Address</b>	<b>Phone Number</b>
<b>Name of Contact</b>	<b>Relationship to Athlete</b>	<b>Phone Number</b>
<b>Name of Contact</b>	<b>Relationship to Athlete</b>	<b>Phone Number</b>