HealthLinc
YOUR COMMUNITY HEALTH CENTER®

Today's Date:		Date of Birth:
Patient Legal Name:		Social Security:
Patient Preferred Name:	US Resident: ☐Yes ☐No	Refugee: ☐Yes ☐No
Address:		Telephone:
City: State: Zip Code:		Township/County:
Email Address:	Veteran: ☐Yes ☐No Discharged: ☐Yes ☐No	Date of Discharge: / /
Emergency Contact:	Relationship:	Telephone:

GENDER IDENTITY

- ☐ Male
- ☐ Female
- ☐ Transgender Male/ Female-to-Male
- ☐ Transgender Female/ Male-to-Female
- ☐ Other
- ☐ Declined to answer

SEXUAL ORIENTATION

- ☐ Straight
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Other
- ☐ Unknown
- ☐ Declined to answer

MARITAL STATUS

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

EMPLOYMENT

- ☐ Full Time
- ☐ Part Time
- ☐ Student

ANNUAL HOUSEHOLD INCOME

- ☐ $0 - $20,000
- ☐ $20,001 - $50,000
- ☐ $50,001 - $100,000
- ☐ $100,001 +

RACE

- ☐ Black/African-American
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ American Indian/Alaskan National
- ☐ White
- ☐ More than one race
- ☐ Refused

ETHNICITY

Are you Hispanic/Latino? ☐Yes ☐No

INSURANCE

- ☐ Patient Refused Intake
- ☐ Uninsured
- ☐ Medicare
- ☐ Medicaid
- ☐ Medicaid Pending
- ☐ HIP
- ☐ Private Insurance

Insurance Provider:
Member ID:

SPECIAL POPULATION (Check any that apply)

- ☐ Migratory/Seasonal Agricultural Worker
- ☐ Recipient of Section 8 or Housing Assistance
- ☐ Homeless

PRIMARY LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Other

Are you proficient in English? ☐Yes ☐No

I understand that the information which I submit is subject to verification by HealthLinc, federal and/or state enforcement agencies, and others as required. Under penalty of perjury and/or fraud, I affirm that the above information is true and correct.

_____ _____

Applicant (signature) *Applicant* (printed name)

HealthLinc
YOUR COMMUNITY HEALTH CENTER®

Mobile School-Based Health Center

Patient Legal Name: _____

Medical History:

Name of student's medical provider: _____

List any medications child is currently taking: _____

List any allergies to food, medications or insects: _____

_____

List all medical conditions: _____

_____

_____

Past surgeries: _____

_____

Has your child had Chickenpox? ☐ Yes ☐ No

Any other medical information you feel necessary for us to know to treat your child

_____

_____

_____

Mobile School-Based Health Center Health Insurance Information

1-888-580-1060
Healthlincchc.org

Health Insurance: ☐ Yes ☐ No See sliding fee scale information below

Please Note: Please fill out the following information in order for us to file your insurance. If we are not able to collect from your insurance, you will be responsible for any services that are rendered.

Primary Insurance: Medical_____ **Dental**_____

Policy Number: _____ Group Number:_____ID Number: _____

Policy Holder (Name on card):_____Date of Birth_____

Relationship to patient:_____Ins Billing address_____

Secondary Insurance: _____

Policy Number:_____ Group Number:_____ID Number _____

Policy Holder (Name on card):_____Date of Birth: _____

Relationship to patient:_____Ins Billing address_____

Responsible Party (Person Responsible for Bill):

Name:_____ Relationship to patient: _____

Address:_____ Apt #:_____

City:_____ State:_____ Zip: _____

SS#:_____ Date of Birth: _____

Home Phone: _____Cell: _____Work: _____

Insured's Employer: _____

Sliding Fee Scale

We will charge persons receiving health services at the usual and customary rate prevailing in this area. Health services will be provided at a reduced charge to persons unable to pay for services. In addition, persons will be charged for services to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.

We will not discriminate against any person receiving health services because of their inability to pay for services, or because payment of the health services will be made under Part A or B of the Title XVIII ("Medicare") or the Title XIX ("Medicaid") of the Social Security Act. The determination of qualification is based on the number of members in the household and the following information:

Any of these items will be accepted):

- Most recent tax filing with the IRS and/or W2's from employer(s).
- A copy of Social Security or Disability Award letter(s) or unemployment statement(s).
- Pay stubs from all employers for the last 30-day period.
- If unemployed, no income and living with others, we require a signed and dated letter from the person providing support of the patient.
- Driver's license or state ID card.
- Marketplace income verification

Mobile School-Based Health Center(MSBHC)

CONSENT FOR TREATMENT

I give permission for: _____
(please print) Student's Last Name First Name Middle Name

to receive health services from the MSBHC at my child's school. The school-based health center may not be able to take care of all the health needs my child may have. However, if he or she is not already under the regular care of a doctor or clinic, I will work with the MSBHC staff to choose one.

1. **I give consent for my child to receive MSBHC services**: I have read the information about the school-based health center and the release of information, and understand what services the MSBHC will and will not provide. My consent will allow my child to receive health services (including routine immunizations and lab testing, as well as behavioral or mental health consulting) while he/ she is a student at this school. If I change my mind, I must write a letter to the MSBHC stating my intentions. It will also be my responsibility to notify the MSBHC staff about changes in the guardianship, address, and phone number of my child.

2. **Information Privacy:** We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regard to your child's personal health information. The terms of the notice may change from time to time. The current notice will be posted at our facilities, on our website, and copies will be available for you to take.

3. **_____** (Parents Initials) I acknowledge that I have received a copy of the **MSBHC NOTICE OF PRIVACY PRACTICES.**

4. **Release of Information:** I understand that services provided by the MSBHC are confidential. The MSBHC will use and disclose my child's personal health information to provide treatment, to receive payment for care (if applicable,) and for improvement of healthcare operations. My child's information may be shared with the school health office (with my child's doctor, my child's school nurse, school social worker or with my child's insurance provider), that may have my child as a patient. I also authorize the use of information from my child's medical record for the purposes of medical care, treatment, clinic administration, and evaluation. In addition, I give my consent to the MSBHC to look at my child's school health record, including health history and vaccination records, in order to provide information that may assist the clinic staff in helping my child.

Signature of Parent/Guardian:_____Date: _____

SERVICES WILL NOT BE PROVIDED WITHOUT PARENTAL CONSENT AS REQUIRED BY THE INDIANA STATE LAW

PRE-PARTICIPATION PHYSICAL EVALUATION FORM (PPE)

The IHSAA Pre-participation Physical Evaluation (PPE) is the first and most important step in providing for the well-being of Indiana's high school athletes. The form is designed to identify risk factors prior to athletic participation by way of a thorough medical history and physical examination. The IHSAA, under the guidance of the Indiana State Medical Association's Committee on Sports Medicine, requires that the PPE Form be signed by a physician (MD or DO), nurse practitioner or physician assistant holding a license to practice in the State of Indiana. In order to assure that these rigorous standards are met, both organizations endorse the following require-ments for completion of the PPE Form:

1. The most current version of the IHSAA PPE Form must be used and may not be altered or modified in any manner.

2. The PPE Form must be signed by a physician (MD or DO), nurse practitioner or physician assistant only after the medical history is reviewed, the examination performed, and the PPE Form completed in its entirety. No pre-signed or pre-stamped forms will be accepted.

3. **SIGNATURES**
   - ❑ The signature must be hand-written. No signature stamps will be accepted.
   - ❑ The signature and license number must be affixed on page three (3).
   - ❑ The parent signatures must be affixed to the form on pages two (2) and five (5).
   - ❑ The student-athlete signature must be affixed to pages two (2) and five (5).

4. Distribution
   - ❑ History Form retained by Physician/Healthcare Provider
   - ❑ Examination Form and Consent and Release Form signed and returned to member school.

Your cooperation will help ensure the best medical screening for Indiana's high school athletes.

PREPARTICIPATION PHYSICAL
HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment. History Form is retained by physician/healthcare provider.

Name: _____ Date of birth: _____

Date of examination: _____ Grade: _____

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? It 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).

_____

Are your required vaccinations current? _____

Patient Health Questionnaire Version 4 (PHQ-4)

Overall, during 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 poly-morphic 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, tingling, 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 food and 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: _____

PHYSICAL EXAMINATION

(Physical examination must be performed on or after April 1 by a health care professional holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) Rule 3-10

Name _____ Date of birth _____ Grade _____ IHSAA member School _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - 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, chewing tobacco, snuff, or dip?
   - During the last 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or use any other appearance/performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5-14)

EXAMINATION		
Height	Weight	☐ Male ☐ Female
BP / (/)	Pulse	Vision R 20/ L 20/ Corrected? Y N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insuffiency		
Eyes/ears/nose/throat		
• Pupils equal		
• Hearing		
Lymphnodes		
Heart		
• Murmurs (auscultation standing, supine, +/- Valsalva)		
• Location of point of maximal impuluse (PMI)		
Pulses		
• Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
• MSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		

MUSCULOSKELETAL

	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		

	NORMAL	ABNORMAL FINDINGS
Knee		
Leg/ankle		
Foot/toes		
Functional		
• Duck-walk, single leg hop		

☐ Cleared for all sports without restriction ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for_____

☐ **Not cleared** ☐ Pending further evaluation ☐ For any sports

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam 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 physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Health Care Professional (print/type) _____ Date _____

Address _____ Phone _____ License # _____

Signature of Health Care Professional _____, MD, DO, PA, or NP (Circle one)

IHSAA ELIGIBILITY RULES

INDIVIDUAL ELIGIBILITY RULES (Grades 9 through 12)

ATTENTION ATHLETE: Your school is a member of the IHSAA and follows established rules. To be eligible to represent your school in interschool athletics, you:

1. must be a regular bona fide student in good standing in the school you represent; must have enrolled not later than the fifteenth day of the current semester.
2. must have completed 10 separate days of organized practice in said sport under the direct supervision of the high school coaching staff preceding date of participation in interschool contests. (Excluding Girls Golf – SeeRule 101)
3. must have received passing grades at the end of their last grading period in school in at least seventy percent (70%) of the maximum number of full credit subjects (or the equivalent) that a student can take and must be currently enrolled in at least seventy percent (70%) of the maximum number of full credit subjects (or the equivalent) that a student can take. Semester grades take precedence.
4. must not have reached your twentieth birthday prior to or on the scheduled date of the IHSAA State Finals in a sport.
5. must have been enrolled in your present high school last semester or at a junior high school from which your high school receives its students . . .
   - . . . unless you are entering the ninth grade for the first time.
   - . . . unless you are transferring from a school district or territory with a corresponding bona fide move on the part of your parents.
   - . . . unless you are a ward of a court; you are an orphan, you reside with a parent, your former school closed, your former school is not accredited by the state accrediting agency in the state where the school is located, your transfer was pursuant to school board mandate, you attended in error a wrong school, you transferred from a correctional school, you are emancipated, you are a foreign exchange student under an approved CSIET program. You must have been eligible from the school from which you transferred.
6. must not have been enrolled in more than eight consecutive semesters beginning with grade 9.
7. must be an amateur (have not participated under an assumed name, have not accepted money or merchandise directly or indirectly for athletic participation, have not accepted awards, gifts, or honors from colleges or their alumni, have not signed a professional contract).
8. must have had a physical examination between April 1 and your first practice and filed with your principal your completed Consent and Release Certificate.
9. must not have transferred from one school to another for athletic reasons as a result of undue influence or persuasion by any person or group.
10. must not have received in recognition of your athletic ability, any award not approved by your principal or the IHSAA.
11. must not accept awards in the form of merchandise, meals, cash, etc.
12. must not participate in an athletic contest during the IHSAA authorized contest season for that sport as an individual or on any team other than your school team. (See Rule 15-1a) (Exception for outstanding student-athlete – See Rule 15-1b)
13. must not reflect discredit upon your school nor create a disruptive influence on the discipline, good order, moral or educational environment in your school.
14. students with remaining eligibility must not participate in tryouts or demonstrations of athletic ability in that sport as a prospective post-secondary school student-athlete. Graduates should refer to college rules and regulations before participating.
15. must not participate with a student enrolled below grade 9.
16. must not, while on a grade 9 junior high team, participate with or against a student enrolled in grade 11 or 12.
17. must, if absent five or more days due to illness or injury, present to your principal a written verification from a physician licensed to practice medicine, stating you may participate again. (See Rule 3-11 and 9-14.)
18. must not participate in camps, clinics or schools during the IHSAA authorized contest season. Consult your high school principal for regulations regarding out-of-season and summer.
19. girls shall not be permitted to participate in an IHSAA tournament program for boys where there is an IHSAA tournament program for girls in that sport in which they can qualify as a girls tournament entrant.

This is only a brief summary of the eligibility rules.

You may access the IHSAA Eligibility Rules (By-Laws) at www.ihsaa.org

Please contact your school officials for further information and before participating outside your school.

(Consent & Release Certificate - on back or next page)

CONSENT & RELEASE CERTIFICATE

I. STUDENT ACKNOWLEDGMENT AND RELEASE CERTIFICATE

A. I have read the IHSAA Eligibility Rules (next page or on the back) and know of no reason why I am not eligible to represent my school in athletic com- petition.
B. If accepted as a representative, I agree to follow the rules and abide by the decisions of my school and the IHSAA.
C. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, illness and even death, is a possible result of such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved, and agree to release and hold harmless my school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any from their own negligence, for any injury, illness or claim resulting from such athletic participation and agree to take no legal action against my school, the schools involved or the IHSAA because of any accident or mishap involving my athletic participation.
D. I consent to the exclusive jurisdiction and venue of courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me, including but not limited to any claims or disputes involving injury, eligibility or rule violation.
E. I give the IHSAA and its assigns, licensees and legal representatives the irrevocable right to use my picture or image and any sound recording of me, in all forms and media and in all manners, for any lawful purposes.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION. (to be signed by student)

Date:_____ **Student Signature: (X)** _____

Printed: _____

II. PARENT/GUARDIAN/EMANCIPATED STUDENT CONSENT, ACKNOWLEDGMENT AND RELEASE CERTIFICATE

A. Undersigned, a parent of a student, a guardian of a student or an emancipated student, hereby gives consent for the student to participation in the following interschool sports ***not marked out:***
Boys Sports: Baseball, Basketball, Cross Country, Football, Golf, Soccer, Swimming, Tennis, Track, Wrestling.
Girls Sports: Basketball, Cross Country, Golf, Gymnastics, Soccer, Softball, Swimming, Tennis, Track, Volleyball.
Unified Sports: Unified Flag Football, Unified Track & Field

B. Undersigned understands that participation may necessitate an early dismissal from classes.

C. Undersigned consents to the disclosure, by the student's school, to the IHSAA of all requested, detailed financial (athletic or otherwise), scholastic and attendance records of such school concerning the student.

D. Undersigned knows of and acknowledges that the student knows of the risks involved in athletic participation, understands that serious injury, illness and even death, is a possible result of such participation and chooses to accept any and all responsibility for the student's safety and welfare while participating in athletics. With full understanding of the risks involved, undersigned releases and holds harmless the student's school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any from their own negligence, for any injury or claim resulting from such athletic participation and agrees to take no legal action against the IHSAA or the schools involved because of any accident or mishap involving the student's athletic participation.

E. Undersigned consents to the exclusive jurisdiction and venue of courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me or the student, including but not limited to any claims or disputes involving injury, eligibility, or rule violation.

F. Undersigned gives the IHSAA and its assigns, licensees and legal representatives the irrevocable right to use any picture or image or sound re- cording of the student in all forms and media and in all manners, for any lawful purposes.

G. Please check the **appropriate space:**

❑ The student has adequate family insurance coverage. ❑ The student does not have insurance

❑ The student has football insurance through school.

Company: _____ Policy Number: _____

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION.
(to be completed and signed by all parents/guardians, emancipated students; where divorce or separation, parent with legal custody must sign)

Date: _____ **Parent/Guardian/Emancipated Student Signature:** (X) _____

Printed: _____

Date: _____ **Parent/Guardian Signture:** (X) _____

Printed: _____

CONSENT & RELEASE CERTIFICATE
Indiana High School Athletic Association, Inc.
9150 North Meridian St., P.O. Box 40650
Indianapolis, IN 46240-0650

File In Office of the Principal
Separate Form Required for Each School Year

DLC: 2/24/2021
g:/printing/forms/schools/2020-21PhysicalForm/2021physicalform.pdf