DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Hopi Health Care Center
P.O. Box 4000
Polacca, Arizona 86042-4000

May 17, 2018

Hopi Schools

Dear Parents/Patients;

The Hopi Health Care Center (HHCC) is gearing up to start accepting appointments for the 2018-19 Sports Physical Examinations (PE). These appointments will begin on June 1st and run into August/September 2018. We are hopeful we will get at least two weekend PE clinics in place in August sometime. This will be announced when dates are confirmed.

Here are the guidelines we are asking parents/guardians to follow:

- Call the appointment desk at 928-737-6081 to schedule your child's/children's PE
- If you are designated as a legal guardian please provide valid documentation (Power of Attorney).
- PE forms must be provided by the parent/student and their personal information filled out on the form (name, DOB, address, etc.) prior to appointment.
- If you are not bringing your child for the appointment, send a note with the adult who will bring your child giving us a name and your authorization for them to accompany them and sign immunization paperwork.
- Empaneled children at HHCC will be scheduled with their Primary Provider for their PE.
- If your child does not receive his/her care at HHCC, medical history (health condition(s), medications, allergies, etc.) must be obtained by visiting Medical Records to sign a Release of Information (ROI) form. We will not schedule your appointment until these documents are received
- For children that do not have a designated Primary Provider (empaneled) at HHCC, we will discuss with you the ability to become empaneled to the provider they see for their PE.

If you have questions, please feel free to call me at 928-737-6241. We look forward to serving our local students for their upcoming 2018-19 school year sports PE's.

Sincerely,

Carletta J Joshevama, RN
Supervisory Clinical Nurse – Outpatient Nursing
Hopi Health Care Center

HOPI HEALTH CARE CENTER
PO Box 4000
Polacca, AZ 86042-4000

Name_____Sex_____Age_____Date of Birth_____Grade_____

Address_____Phone_____

In case of emergency, contact: Name_____

Explain "yes" answers below. Phone(H)_____(W)_____

Circle questions you don't know the answer to. Cell Phone:_____

	Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical? Do you have an ongoing or chronic illness? Are you currently being treated for an injury or condition?		
2. Have you ever been hospitalized overnight? Have you ever had surgery?		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?		
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
4. Do you have any allergies to medications? _____ Do you have any allergies to pollen, food or stinging insects?		
Have you ever had a rash or hives develop during or after exercise?		
5. Have you ever passed out during or after exercise? Have you been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month? Has a doctor ever denied or restricted your participation in sports for any heart problems? Has anyone in your immediate family had the following conditions? Diabetes_____Heart disease_____other_____ Sudden death prior to age 50_____High Blood Pressure_____		

	Yes	No
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?		
8. Have you ever become ill from exercising in the heat?		
9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you use an inhaler? Do you have seasonal allergies that require medical treatment?		
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? _____		
11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?		
12. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		

If yes, check appropriate box below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

Explanation:_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that truthful and accurate information is essential in properly determination whether the student should be cleared for athletic participation

I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

_____ _____ _____

Signature of Parent/Guardian Signature of Student Athlete Date

Keams Canyon Elementary School
PO Box 397
Keams Canyon, AZ 86034

ANNUAL PARTICIPATION PHYSICAL EXAMINATION

ANNUAL PHYSICAL EXAMINATION

Name:_____Date_____

Height:_____Weight:_____ Pulse:_____BP:_____

Vision: R20/_____ L20/_____ Glasses/Contacts: Yes[ ] No[ ] Pupils: Equal _____Unequal_____

	Normal	Abnormal Findings	Initials*
Medical			
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/Oropharynx			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station-based question only

*Other studies/Evaluations/Comments (if applicable):

_____

_____

_____

Immunizations Up to Date? [ ] Yes [ ] No (Copy attached)

CLEARANCE

[ ] Cleared

[ ] Cleared after completing evaluation/rehabilitation for:_____

_____

_____

[ ] Not Cleared for:_____Reason:_____

Recommendations:_____

_____

Name of Physician (print/type)_____Date_____

Address_____Phone_____

Signature of Physician_____MD/DO/NP/PA-C