Greetings!

My name is Joan Connell. I am a pediatrician from Bismarck CHI St. Alexius. I am excited to partner with Dr. Peter Sandroni and the Family Medicine residents from Minot UND Center for Family Medicine and the FDHU McHenry County Public Health team to offer your 11-18 year old student(s) ***FREE*** well child/adolescent checks at the TGU Towner School on Monday, June 8, 2026.

During these well checks, we will listen to concerns you/your child have, ask questions about general health issues (sleeping, exercise, diet, mental health, dental care, etc.) as well as perform physical exams and some screening tests (vision check. anxiety/depression screens). We will discuss our findings with your child as well as any recommendations if we find something that needs to be evaluated more closely or treated. We will also discuss healthy lifestyle topics.

If interested, we will provide sports physicals/clearances for those interested in participating in sports during the 2026-27 school year. Finally, we will be able to provide immunizations to your child if any are needed.

To participate, please complete and return the following paperwork to the school OR to Nancy Bryn at the FDHU McHenry County office In Towner. (Phone 701-537-5732). Call Nancy at the Towner office at 701-537-5732 to schedule your child!

- 2 Consent to Treat Forms: Must be signed by a parent or guardian.
- Personal History Form: Please complete all sections.
- Vaccine Administration Record: Must be signed by a parent or guardian ***if*** you would like your child to receive vaccines which are due.
- NDHSAA Physical Form: Complete and sign this form (along with the student- athlete) ***if*** you are requesting a sports physical.
- Fluoride varnish consent form-must be signed by parent/guardian to receive fluoride

All forms must be fully completed, signed, and returned for your child to receive care. Thank you for your time and attention; We look forward to providing this service for your student.

All my best,

Joan Connell, MD
Mandan Medical Plaza
701-667-4600 (Work)

Date: ____________________ **Consent to Treatment Form 1**

I ____________________ have read and fully agree to each of the statements in this form and sign below as my free and voluntary act. UND CFM will not be bound by any changes I make to this document. I have been given the opportunity to have my questions answered about this form and the CHI Health Consent to Treatment. Except for services that I receive on an emergency basis, I understand that if I refuse to sign this document as presented, CHI Health may not be able to provide services to me.

Patient Name:____________________ Patient's Date of Birth:____________________

X ____
Signature of patient or legally authorized representative to patient

____
Printed Name of legally authorized representative to patient

Relationship to patient: Self Parent Guardian Other:____________________

Additional Services Options – please check all that apply:

Sports Physical:

☐ I would like a sports physical for the upcoming academic year.
*Checking this box will require you to complete, sign and return the 2-page NDHSAA sports history form
☐ I do NOT want a sports physical.

Fluoride Varnish:
☐ I would like fluoride varnish for my child's teeth.
*Checking this box will require you to complete, sign and return the Fluoride Varnish Consent Form
☐ I do NOT want fluoride varnish.

Vaccinations:
☐ Meningitis ACWY
☐ Meningitis B
☐ Tdap
☐ HPV
*Checking any of the above boxes will require you to complete, sign and return the Vaccine Consent form
☐ I do NOT want vaccines today

Name (First, Middle, Last) ____

Date of Birth: _____/_____/_____ Gender (circle one) Female Male

Race: White American Indian Alaska Native Asian Black or African American Pacific Islander Other: ______

Hispanic or Latino (circle one): Yes No

Mailing Address: ____

City, State, Zip: ____

Telephone Number: ____________________ (parent's number to be able to reach on screening day)

CONSENT TO TREATMENT FORM 2

Adolescent Well Check Clinic

Consent to Treatment: I have a condition requiring examination, diagnosis, and treatment and hereby consent to and authorize such customary care including but not limited to x-ray, laboratory, routine diagnostic tests and therapeutic procedures ("Services") performed by my admitting and treating physician(s), which may or may not be employed by the hospital and his or her assistants or designees, including personnel employed by CHI Health. I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I Consent to this and for CHI Health to retain ownership rights to these images. A separate consent for photography form will be obtained for disclosure of any images outside of CHI Health that identify me and are used for purposes such as education and marketing. I understand that such care may involve risks and that no guarantees have been made to me concerning the results of this treatment or examination. I further understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures/treatment. For any notice or authorization referenced herein a copy of this form can be used in place of the original.

Clinical Education and Research: I agree to the supervised participation of health care learners (e.g., medical students, nursing students, interns, residents, fellows, non-physician clinical students, etc.) in my care. I understand that patient records and specimens obtained from my body for medical care purposes may be retained and used for educational and research purposes in accordance with applicable regulations. Tissue shall be disposed of in accordance with the hospital's usual and customary practices.

Independent Status of Physicians: I recognize that not all physicians, and health care providers including, but not limited to, Certified Registered Nurse Anesthetists, Radiologists, Emergency Medicine physicians, Anesthesiologists, Physical, Occupational and Speech Therapists, residents or medical students (under the supervision of physicians and/or residents) who provide Services to me during this admission are employees or agents of CHI Health. Such individuals are INDEPENDENT CONTRACTORS who are granted privileges to use CHI Health Facilities for private Patients and bill separately for their Services. In addition, I understand that CHI Health is not responsible for nor does it assume any liability for the acts or omissions of any such independent contractors.

Assignment of Facility Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to CHI Health and authorize direct payment to CHI Health. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Assignment of Professional Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to all physician(s) and/or medical professionals providing services to me and authorize direct payment to physician(s). This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Authorized Representative: I hereby authorize CHI Health, its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by CHI Health.

Financial Responsibility: I understand that I am financially responsible to CHI Health as the patient, parent, guardian, conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, out-of-pocket expenses, or the extra cost of a private room in which I am placed at my own request. I authorize CHI Health or physician(s) to access and review my credit report for purposes related to billing or collection of accounts payable to CHI Health or physician(s).

Communications Consent: By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from hospital, its staff, its contractors, collection agents, and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving health care services.

Advance Instructions for Health Care: I understand that I may indicate in writing (Advance Directives, i.e. Living Will and Durable Power of Attorney for Health Care) my desire to receive, select and/or define medical or surgical treatment or choose non-treatment. CHI Health will recognize such instructions in accordance with applicable state law and CHI Health policies if either or both Advance Directive statements(s) are provided to CHI Health so that a copy can be filed with my medical record.

Personal Equipment and Valuables: I understand that CHI Health Facilities maintain an area for safekeeping of money and valuables. I understand that, except for such money and valuables which I deposit with CHI Health for safekeeping, CHI Health shall not be liable for the loss or damage of my personal property. I accept full responsibility for all property kept in my possession. I also understand that I must inform the admissions clerk or a nurse if I bring any electrical equipment to the CHI Health Facility (e.g. ventilators; BIPAP machine, CPAP machine) and adhere to CHI Health policies regarding its use. I assume full responsibility for such electrical equipment and for any injury caused by the use of the electrical equipment brought from home.

Patient Rights: I, the undersigned, have received a separate document informing me of my rights and responsibilities as a patient.
For all patients:
Acknowledgement of receipt of notice of privacy practices.
Please Initial: ______ I acknowledge receipt of CHI Health's Notice of Privacy Practices.

For Hospital Patients Only:
Acknowledgement of receipt of patient rights and responsibilities information.
Please Initial: ______ I acknowledge that I was provided with information about my patient rights and responsibilities.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent or is duly authorized by or on behalf of the parent to execute the above and accept its terms.

Patient's Signature / Parent if Minor / Power of Attorney / Guardian	Date	Time ☐ a.m. ☐ p.m.
Patient Representative's Signature	Relationship to Patient	
Witness to Signatures	Date	Time ☐ a.m. ☐ p.m.
Patient Unable to Sign Consent Because	Name and/or ID of Interpreter, if used / applicable	

18613 v15 (Rev 8/2022)

Personal History

CHI Health.

Personal Medical History (Check if you presently have or have had any of the following.)

- ☐ Acid reflux/GERD
- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Cancer If so what type? ______
- ☐ Chronic pain If so where? ______
- ☐ Concussion
- ☐ Congenital problems
- ☐ Congestive heart failure
- ☐ Diabetes
- ☐ Dizziness/fainting
- ☐ Frequent infections (ear/lung/sinus)
- ☐ Gastrointestinal problems
- ☐ Growth/Developmental problems
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Menstrual disorder
- ☐ Mental illness
- ☐ Migraine headache
- ☐ Muscle/Bone problem
- ☐ Prostate disease
- ☐ Pulmonary disease
- ☐ Rheumatic fever
- ☐ Seizures/Convulsions
- ☐ Sexually transmitted infection
- ☐ Sickle cell disease/trait
- ☐ Skin problems
- ☐ Sleep problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary problem
- ☐ Vision/Eye problems
- ☐ Other ______
- ☐ Other ______

Current Medications: (include vitamins/supplements) (continued on back)	**Drug Allergies:** include reaction (continued on back)	**Environmental Allergies:** include reaction (i.e. latex, pollen, foods) (continued on back)

Hospitalizations and Major Surgeries (continued on back)

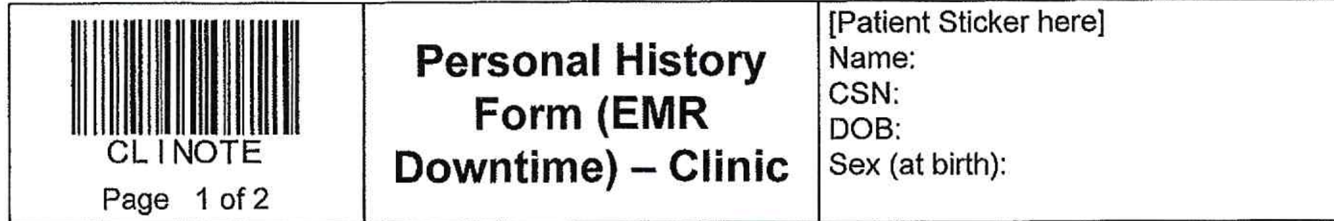
Reason	Year/Age	Reason	Year/Age

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Other	Describe
Heart Disease	☐	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	
Migraine Headache	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	
Bleeding Disorder	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	
Epilepsy/ Seizures	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	

Habits — How much/How long	Living Will	Women Only:
☐ Alcohol ☐ Marijuana ☐ Caffeine ☐ Recreational drugs ☐ Tobacco	Do you have a living will? ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No Planning pregnancy ☐ Yes ☐ No Using birth control ☐ Yes ☐ No Method______ Number of pregnancies:______ Number of births:______

Date of Visit	Time of Visit	Clinic Specialty	Clinic Location	Provider



CL I NOTE

Page 1 of 2

Personal History Form (EMR Downtime) – Clinic

[Patient Sticker here]
Name:
CSN:
DOB:
Sex (at birth):

Current Medications: (include vitamins/supplements) (continued from front)	**Drug Allergies:** include reaction (continued from front)	**Environmental Allergies:** include reaction (i.e. latex, pollen, foods) (continued from front)

Hospitalizations and Major Surgeries (continued from front)

Reason	Year/Age	Reason	Year/Age

Provider Signature			Date	
Date of Visit	Time of Visit	Clinic Specialty	Clinic Location	Provider

Page 2 of 2	**Personal History Form (EMR Downtime) – Clinic**	[Patient Sticker here] Name: CSN: DOB: Sex (at birth):

FDHU VACCINE CONSENT

Information is for the person receiving the vaccine. Please print. Use full legal name.

First Name: ______________________ MI: ___ Last: ______________________ Date of Birth: __________

Mailing Address: ____ Telephone: __________________

Age: _____ Gender: F or M Email: ______________________ **Preferred language:** English or Other:________

Race: To better serve our population, circle all that apply: White American Indian Asian Black or African American

Alaskan Native Hispanic/Latino Pacific Islander Other____________ Unknown Prefer not to answer

Insurance Company: ________________________ Policy #: ______________________ Group #: ________

Secondary Insurance Co: ____________________ Policy #: ____________________ Group #: _________

Medicaid Number: _____________________ ☐ No insurance (Under 18 will be billed $20.90 per dose)

Health Questions for the person who is receiving vaccines or a blood draw:		
Has the person eaten today?	☐ Yes	☐ No
Ever felt dizzy or faint before, during or after a shot or a blood draw? Feel anxious today?	☐ Yes	☐ No
Feel sick today?	☐ Yes	☐ No
List allergies to medications, food, or latex.	☐ Yes	☐ No
Have a long-term health problem with lung, heart, kidney, liver, brain/nervous system, metabolic disease (e.g., diabetes), asthma, blood disorder, no spleen, a cochlear implant, or spinal fluid leak?	☐ Yes	☐ No

Additional Health Questions for the person receiving vaccines:		
Ever had a life-threatening reaction to a vaccine in the past?	☐ Yes	☐ No
On long-term aspirin therapy?	☐ Yes	☐ No
Had a seizure or had a parent, brother or sister who has had a seizure? Any brain or other nervous system problems?	☐ Yes	☐ No
Have cancer, leukemia, HIV/AIDS, or any immune system problem? Have a parent, brother, or sister with an immune system problem?	☐ Yes	☐ No
In the past 6 months, taken medications affecting 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?	☐ Yes	☐ No
In the past year, received a transfusion of blood or blood products, or immune (gamma) globulin or an antiviral drug?	☐ Yes	☐ No
Been diagnosed with a heart condition (myocarditis/pericarditis), or had a history of Multisystem Inflammatory Syndrome (MIS-C) after an infection with COVID virus?	☐ Yes	☐ No
Had vaccinations in the past 4 weeks?	☐ Yes	☐ No
Uses Tobacco or e-cigarettes?	☐ Yes	☐ No
Females only: pregnant or could become pregnant during the next month?	☐ Yes	☐ No
Babies only (under 8 months): had intussusception (bowel obstruction)?	☐ Yes	☐ No

I have viewed the Vaccine Information Statement at www.immunize.org. A copy may be requested from First District Health Unit 701-852-1376. I have read the information about the vaccine(s). **I consent for immunizations to be given to the person named above & am authorized to give consent.** FDHU **Notice of Privacy Practices** is available online. **I agree to pay, and I am financially responsible** for charges not covered by a third-party payer. I assign and **authorize any third-party payer/insurer** to make direct payment to FDHU. I authorize the release of information necessary to process this claim. Information will be shared with the ND Immunization Information System.

SIGNATURE OF CLIENT OR PERSON AUTHORIZED TO CONSENT ON THE CLIENT'S BEHALF TO RECEIVE VACCINATION:

X____ **DATE:**__________________

NDHSAA Preparticipation Physical Evaluation Form

Starting with the 2010-11 school year, student athletes participating in NDHSAA sanctioned sports programs will be required to file a pre-participation health history screening and physical examination clearance form (page 4) with their school office prior to their participation on a yearly basis. As per NDHSAA Constitution and By-Laws, physical evaluations may be done by the following medical professionals: Medical Doctor, Doctor of Osteopathy, Physicians Assistant, Nurse Practitioner (MD, DO, PA, NP); the Athletic Pre-Participation Health History Screening and Physical Examination is valid for one school year; a physical examination must be completed on or after **April 15** to be valid for participation the following school year.

The NDHSAA approved form explanations appear below:

History Form ....Page 1 & 2

To be filled out by Parent/Athlete prior to physical evaluation The medical facility should keep this form.

Athletes With Disabilities Form:
Supplement to the Athlete History...Page 3

Filled out ONLY if athlete has special needs. The medical facility should keep this form.

Physical Examination Form...Page 4

Completed by medical personnel and retained in medical facility file The medical facility should keep this form.

Medical Eligibility Form ....Page 5

This is the ONLY form that should be returned to the school office. * Parent signature also needed for the school.

■ NDHSAA 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 ________ Age ________ Grade ______ School ______________________

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 poly- morphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

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NDHSAA Board Approval: September 2019

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

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: ____

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NDHSAA Board Approval: September 2019

■ NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

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

Name: ______________________________ Date of Birth______________________

1. Date of disability:
2. Classification (if available):
3. Cause of disability (birth, disease, injury or other):
4. List the sports you are playing:

	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

____

____

Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

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: ______________________

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NDHSAA Board Approval: September 2019

■ NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: ______________________________ Date of birth: ______________________

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, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 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 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, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

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

Name of health care professional (print or type):______________________________Date: ______________

Address:____Phone: ____________________

Signature of health care professional:____, MD, DO, NP, or PA

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NDHSAA Board Approval: September 2019

■ NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: ______________________________ Date of birth: ______________________________

☐ Medically eligible for all 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 on this form. A copy of the physical examination findings are 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 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 or type):______________________________Date: ______________

Address:____Phone: ______________________

Signature of health care professional:______________________________________, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: ____

____

Medications: ____

____

Other Information: ____

____

Emergency Contacts: ____

____

PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission for emergency treatment for my daughter/son. I expect an effort will be made to contact me if an emergency occurs. I understand the cost for any medical attention may not be covered or paid by any high school or the North Dakota High School Activities Association. I hereby approve participation in athletic activities.

Grade of Athlete_______ School______________________ Sport(s)______________________________

Parent/Guardian Signature ______________________________ Date ______________________

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Fluoride Varnish Consent Form

A licensed health professional will be applying fluoride varnish to your teeth as a means of preventing tooth decay (cavities).

Fluoride varnish is a protective coating that is painted on teeth. The varnish releases fluoride over a period of time, which strengthens teeth and prevents tooth decay. Tooth decay is the most common chronic disease found in children.

___ YES, I would like my child/myself to receive the fluoride varnish application.

___ NO, I do not wish for my child/myself to receive the fluoride varnish application.

Does the person receiving fluoride varnish see a dentist at least once per year? ___ YES ___ NO

If Yes, name of dentist: ________________________ Last visit: ___________________

_____________________________________ ___________________

Signature of Parent/Caregiver/Self Date

_____________________________________ ___________________

Please print name of Parent/Caregiver/Self Date

Please print. Use full, legal name of person receiving fluoride varnish.

First:_____________________________ Middle Initial:__________ Last: ______________________________

Fluoride Varnish

WHY DO WE RECOMMEND PUTTING FLUORIDE VARNISH ON CHILDREN'S TEETH?

- Tooth decay is one of the most common preventable diseases in children.
- Children as young as 9 months can get cavities.
- Cavities in baby teeth can make eating, speaking, sleeping and learning difficult.
- Children do not lose all of their baby teeth until they are about 11 to 12 years old.
- Fluoride varnish can reduce cavities by 40%.

IS FLUORIDE VARNISH SAFE?

- Yes! Fluoride varnish is Food and Drug Adminstration (FDA) approved and American Dental Association endorsed.
- Fluoride varnish is non-toxic and can be used on baby teeth.

WHAT IS FLUORIDE VARNISH?

- Fluoride varnish is a protective varnish that is applied on teeth.
- Fluoride varnish helps prevent new cavities and can help stop some cavities that have just barely started.

HOW IS FLUORIDE VARNISH PUT ON TEETH?

- The varnish is applied on the teeth with a small brush.
- It is quick, easy, painless, and tasteless.

HOW LONG DOES THE FLUORIDE VARNISH LAST?

- Very small amounts of the varnish remain on the teeth and release fluoride for 4-6 months.
- The fluoride varnish can be applied every 4-6 months.

Instructions for Care After Treatment

After the application of the fluoride varnish, your child will feel a coating and may notice a difference in the color of their teeth. To obtain the maximum benefit from the fluoride varnish, follow these simple steps:

- Do not remove the fluoride varnish by brushing or flossing for at least 4-6 hours
- If possible, wait until the next morning to resume normal oral hygiene
- Eat soft foods and avoid hot drinks and products that contain alcohol (i.e. mouth washes/ oral rises) until after your child brushes their teeth.

WHAT IF MY CHILD SEES THE DENTIST TWICE A YEAR?

Their teeth can still be varnished! Dentists varnish during cleanings, but fluoride varnish can be applied up to four times a year.

How to Prevent Cavities

- Supervise your child's daily toothbrushing.
- Don't put anything into your mouth and then into your child's mouth. (i.e. pacifier) This can spread bacteria to the child's mouth that can cause cavities. Cavities are contagious!
- Avoid soda and sugary drinks, as they are major sources of cavities. Sugary liquids in bottles can lead to early childhood cavities. Infants should finish their bedtime and nap time bottles before going to bed. Encourage your child to drink from a cup by his/her first birthday.
- Visit your dentist regularly - ideally, twice a year.
- Ask your doctor or dentist about fluoride tablets and fluoride varnish.
- Start cleaning your child's teeth at a young age (9 months to 2 years) with a clean washcloth or soft toothbrush.