



## STUDENT ENROLLMENT FORM

STUDENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

GRADE: \_\_\_\_\_ CAMPUS: \_\_\_\_\_ PARENT/LEGAL GUARDIAN PHONE: \_\_\_\_\_

PARENT/LEGAL GUARDIAN NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

Please read the following statements carefully. **Place your initials next to the statements for which you are providing consent for your child.** By signing this form, you certify that you are the student's parent or legal guardian and have the legal right to make medical decisions for the student.

\_\_\_\_\_ 1. I consent to enroll my child in the Jacket Health and Wellness Center. I further consent for my child to be treated by the Jacket Health and Wellness Center contracted provider. I understand that I can revoke this consent at any time by providing the revocation, in writing, to the Jacket Health and Wellness Center at 512 W. Church Street, Ste A, Sheridan, AR 72150. (This is required for enrollment in the Jacket Health and Wellness Center.) Otherwise this consent will be valid until the student's separation from the district.

\_\_\_\_\_ 2. I consent for my child's photograph to be published on the district's website and social media pages. (This is optional and is not required for enrollment in the Jacket Health and Wellness Center.)

\_\_\_\_\_ 3. I consent for my child to be transported to the Jacket Health and Wellness Center at my request. (This is optional and is not required for enrollment in the Jacket Health and Wellness Center.)

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Printed Name: \_\_\_\_\_

Please indicate your child's current insurance status below. This information is collected as a requirement of the Arkansas Division of Elementary and Secondary Education. All responses are aggregated and reported in total numbers with no identifying information.

☐ Medicaid/AR Kids    ☐ Private Insurance    ☐ No Insurance    ☐ CHIPS    ☐ TriCare

**NO STUDENT WILL BE DENIED MEDICAL CARE IN THE JACKET HEALTH AND WELLNESS CENTER DUE TO INABILITY TO PAY.**

**\*\*additional paperwork will be required prior to your child's first appointment with the Jacket Health and Wellness Center. You may access this paperwork at [www.mainlinehealth.net](http://www.mainlinehealth.net) under "School Based Consent Form". If you would prefer delivery by alternate method, please mark below and provide contact information:**

☐ TEXT: \_\_\_\_\_ ☐ EMAIL: \_\_\_\_\_



**Consent for School Required Physical**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

By signing below, I consent for the above-named student to receive a school required physical. I further consent for the physical to be performed by Mainline Heath Systems.

\_\_\_\_\_  
(Printed name of person giving consent)

\_\_\_\_\_  
(signature of person giving consent)

\_\_\_\_\_  
(Relationship to student)

\_\_\_\_\_  
(Date)

**JACKET**   
HEALTH AND WELLNESS



## Patient Information

Date: \_\_\_\_\_

Patient First Name: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Primary Telephone Number: \_\_\_\_\_ home cell work

Secondary Telephone Number: \_\_\_\_\_ home cell work

Patient Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Patient Social Sec. # \_\_\_\_\_

Patient Gender (circle one): Male Female

Patient Race (circle one): White/Caucasian African American/Black Hispanic/White Asian  
Native Hawaiian American Indian Other Pacific Islander Refuse to Report

Patient Ethnicity (circle one): Hispanic/Latino Non-Hispanic/Latino

Marital Status (circle one): Single Married Divorced Widowed

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Telephone Number: \_\_\_\_\_ home cell work

Emergency Contact Secondary Number: \_\_\_\_\_ home cell work

Relationship to Patient: \_\_\_\_\_

Medical Insurance (circle one): Uninsured Medicaid/ARKids Private Insurance

Subscriber's Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Policy # \_\_\_\_\_

This form was completed by :

\_\_\_\_\_  
*Printed* name of patient or person authorized to consent for patient

\_\_\_\_\_  
*Signature* of patient or person authorized to consent for patient

## ■ 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 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? 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? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(A sum of  $\geq 3$  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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



# ■ PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM



Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> 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 • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), ortinea 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		

\*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings

† 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

† For certain 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. 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 provider: \_\_\_\_\_ Date of exam: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of physician, APN, PA: \_\_\_\_\_