SPORTS PHYSICALS AVAILABLE AT SCHOOL

Save time and money by getting your student's sports physical at school at one of the following locations. Cherry Health's School-Based Health Centers are located steps away from the classroom, where interruptions to the educational process are minimal.

All GRPS students are welcome regardless of insurance status or ability to pay. Medicaid, Medicare, and most other insurance plans are accepted. In addition, a sliding fee payment scale based on income and family size is available to those without insurance.

Call to schedule:

Innovation Central High School Health Center
421 Fountain Street NE
Grand Rapids, MI 49503
(616) 776-5120

Stephanie Todd, NP
Pediatric Nurse Practitioner

Ottawa Hills High School Health Center
2055 Rosewood Ave S
Grand Rapids, MI 49506
(616) 776-5110

Amy Hoogstra, FNP
Family Nurse Practitioner

Union High School Health Center
1800 Tremont Blvd NW
Grand Rapids, MI 49504
(616) 791-6593

Megan Carson, PAC
Physician Assistant

Consent to Treat Form

Sliding Fee Program Application

Michigan Schools Sports Physical Form

Cherry Health
Comprehensive. Quality. *Healthcare.*

GRPS my choice
Grand Rapids Public Schools

Cherry Health
Comprehensive. Quality. *Healthcare.*

School Based Health Center Consent Form

Student Name:	Date of Birth:
School:	Grade:

Services Provided

- Physical exams for school, sports and camp
- Treatment for acute, chronic illness and injuries
- Vision / hearing screenings and followup
- Dental exams, cleanings and x-rays
- Immunizations
- Basic laboratory services and tests
- Crisis intervention *
- Administration of medication
- Referrals for specialty services
- Substance use education, counseling and referrals *
- Individual, group, family and community education
- Mental health and psychosocial assessment, counseling and referrals *
- STD and screening checks *

*** Current Michigan law states that these services do not require parental consent.**

Services NOT Provided:

No birth control pills or devices are dispensed or prescribed.
No abortion counseling, referrals or services provided.

If you want your child to receive any of the following services, **please place a checkmark at the consent checkbox next to each service. Please sign and date the bottom of the form, on the second page and return this form to your child's school.**

Medical Care

☐ **I consent for my child to receive medical care** through the School Based Health Center.
Please note: All required and recommended vaccinations will be given unless otherwise specified by the parent or guardian.

Does your child have health insurance? ☐ Yes ☐ No	Does your child have Medicaid? ☐ Yes ☐ No	Medicaid #:

Other health insurance (Please list the name of insured parent, name of insurance and policy #):

Where do you take your child to see the doctor?	Phone #:	Date of last exam:
List of allergies to medications, food, bee stings, etc:	List current medications your child is taking:	Pharmacy:
Does the child have any medical problems including learning or physical disabilities? ☐ Yes ☐ No	If yes, please list:	
Does the child's siblings or parents have any medical problems or history of cancer? ☐ Yes ☐ No	If yes, please list:	
Has your child ever been a patient in the hospital overnight? ☐ Yes ☐ No	If yes, why?	
Has your child ever had any surgeries? ☐ Yes ☐ No	If yes, describe:	

Dental Care

☐ **I consent for my child to receive dental care** through the School Based Health Center. Some treatments may be delivered by a hygienist or assistant.

Does your child have dental insurance? ☐ Yes ☐ No	Does your child have Medicaid? ☐ Yes ☐ No	Medicaid #:

Other dental insurance (Please list the name of insured parent, name of insurance and policy #):

Where do you take your child to see the dentist?	Phone #:	Date of last exam:

Counseling Services

☐ **I consent for my child to receive counseling services** (Examples: one-on-one counseling, community resource referrals and outreach and coordination of outside resources and/or services).
If the patient is 14 years or older, parental consent is NOT required. *

Patient name:	DOB:	Grade:

Parent / Guardian Information

Mother/Guardian:	DOB:	Home/work phone:
Father/Guardian:	DOB:	Home/work phone:

Parent/Guardian address:

Email address:

Emergency contact:	Relationship:	Phone #:

Household annual income:	# of people in household:	What language is most often spoken at your home?

Is there any other important information we should know?

Would you like to request any other assistance, or have any comments to help the health center serve you better?

Additional Information

Please check the box that best describes your child's race:
☐ American Indian/Alaskan Native ☐ Asian ☐ More Than One Group ☐ Native Hawaiian
☐ Other Pacific Islander ☐ White ☐ Declined to specify ☐ Unknown

Please check the box that best describes your child's ethnicity: ☐ Latino or Hispanic ☐ Not Latino or Hispanic ☐ Decline to specify

Please check the box that best describes your child's current housing situation:
☐ Doubling Up (living with extended family, friends or acquaintances) ☐ Shelter
☐ Not Homeless (legally occupied, single family, owned or rented) ☐ Other
☐ Street (on the street, in cars, abandoned buildings, under bridge) ☐ Unknown/Unreported
☐ Transitional (treatment program, hospital, jail, motel)

Place a checkmark at Yes or No based on your family's primary source of income:

1. In the last 24 months, have you worked on a farm/orchard planting or harvesting crops? ☐ Yes ☐ No

If you answered No, you may skip the next 3 questions.

1. In order to work in agriculture, have you moved during the past 3 years? ☐ Yes ☐ No
2. Due to the seasonal nature of your work in agriculture, have you had to change jobs, reduce the number of hours you work, or been temporarily been laid off during the past 2 years? ☐ Yes ☐ No
3. Have you or family you live with, stopped working in agriculture due to disability or old age? ☐ Yes ☐ No

By signing this consent, I confirm I am the parent/legal guardian of the above listed student and am authorized to give this consent. This consent will be in effect for one year from this date.

Parent/Guardian Signature:	Date:

In order for health center staff members to provide services, I authorize the school to release school records on a "need to know basis" to the School Based Health Center staff members, and also for the School Based Health Center staff members to release medical records to the school and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may include the following; immunization records, class schedules, parental contact, address, phone number, medical and behavioral health conditions, health screenings, medications, health care plans, or attendance information. The medical and mental health providers from the School Based Health Center may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed above to release information to the School Based Health Center staff members as needed. This information may include the following; medical records including lab results, office visits, hospital admissions, vaccinations and BMI (Body Mass Index) information entered into MCIR (Michigan Care Improvement Registry), dental and mental health records. I hereby authorize the School Based Health Center to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served regardless of the ability to pay. I hereby authorize the School Based Health Center staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, School Based Health Center staff members will use and share my Personal Health Information (PHI) for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the location(s) my child receives his/her health care services and on the Cherry Health website.

Cherry Health

Solicitud de estudiante para el Programa de Tarifas Basadas en el Ingreso

El Programa de tarifas basadas en el ingreso permite a los pacientes recibir atención a un costo reducido. Aunque tenga seguro médico, debe solicitar el Programa de tarifas basadas en el ingreso. La información que proporcione en este formulario es **confidencial**.

Información del paciente

Nombre del paciente_____ Fecha de nac. _____

Número de Seguro Social _____ Teléfono _____

Dirección _____

¿Tiene actualmente Medicaid o Medicare? Sí No

Otro nombre del seguro_____ Teléfono del seguro_____

Nombre del suscriptor _____ Fecha de nac del suscriptor _____

Número de póliza_____

La información que proporcioné es correcta a mi leal saber y entender. Entiendo que tengo que informar todo cambio en mis ingresos en un plazo de 30 días posteriores a que ocurra. Cherry Health revisará cada 12 meses si reúno las condiciones, dependiendo del comprobante de ingresos que presente.

Firma del estudiante **Fecha**

Solo Para Uso Interno

Documentation Yes Pending No documented income _____

Sliding Fee qualification: B – 100% C – 75% D – 50% E – 25%

Staff Signature Date Date entered in computer

michigan high school athletic association

MEDICAL HISTORY: Completed by Parent or Guardian or 18-Year-Old

Student Name: _____ Date of Birth: _____

Doctor: _____ Doctor's Phone: _____ Date of Exam: _____

GENERAL QUESTIONS	Y	N
Has a doctor ever denied or restricted your participation in sports for any reason?		
Do you have any ongoing medical conditions? If so, please identify below:		
❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections ❑ Other:		
Have you ever spent the night in the hospital or have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Y**	**N**
Have you ever passed out or nearly passed out DURING or AFTER exercise?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have any heart problems? Check all that apply:		
❑ High blood pressure ❑ Heart murmur ❑ Heart infection ❑ High cholesterol		
❑ Kawasaki disease ❑ Other:		
Has a doctor ordered a test for your heart? (example, ECG/EKG, echocardiogram)		
Do you get lightheaded or feel more short of breath than expected during exercise?		
Do you have a history of seizure disorder or had an unexplained seizure?		
Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Y**	**N**
Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		
BONE AND JOINT QUESTIONS	**Y**	**N**
Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?		
Have you ever had any broken or fractured bones, dislocated joints or stress fracture?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
Do you regularly use a brace, orthotics or other assistive device?		
Do you have a bone, muscle or joint injury that bothers you?		
Do any of your joints become painful, swollen, feel warm or look red?		
Do you have any history of juvenile arthritis or connective tissue disease?		
Have you ever had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?		

MEDICAL QUESTIONS	Y	N
Do you cough, wheeze or have difficulty breathing during or after exercise?		
Have you ever used an inhaler or taken asthma medicine?		
Is there anyone in your family who has asthma?		
Were you born without, or missing a kidney, eye, testicle (males), spleen or any other organ?		
Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you had infectious mononucleosis (mono) within the last month?		
Do you have any rashes, pressure sores or other skin problems?		
Have you had a herpes or MRSA skin infection?		
Do you have headaches or get frequent muscle cramps when exercising?		
Have you ever become ill while exercising in the heat?		
Do you or someone in your family have sickle cell trait or disease?		
Have you had any problems with your eyes or vision or any eye injuries?		
Do you wear glasses or contact lenses?		
Do you wear protective eyewear such as goggles or a face shield?		
Immunization History: Are you missing any recommended vaccines?		
Do you have any allergies?		
Have you ever had a head injury or concussion?		
Do you have any concerns that you would like to discuss with a doctor?		
Have you ever received a blow to the head that caused confusion, prolonged headache or memory problems?		
Have you ever had numbness, tingling, weakness or inability to move your arms or legs after being hit or falling?		
Have you ever had an eating disorder?		
Do you worry about your weight?		
Are you trying to or has anyone recommended that you gain or lose weight?		
Are you on a special diet or do you avoid certain types of foods?		
FEMALES ONLY (Optional)	**Y**	**N**
Have you ever had a menstrual period?		
How old were you when you had your first menstrual period?		
How many periods have you had in the last 12 months?		

CURRENT-YEAR PHYSICAL = GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

PHYSICAL EXAMINATION & MEDICAL CLEARANCE: Completed by MD, DO, PA or NP - RETURN DIRECTLY TO PATIENT

EXAMINATION: Height: Weight: ❑ Male ❑ Female BP: / Pulse: Vision: R 20/ L 20/ Corrected: ❑ Y ❑ N

MEDICAL	NORMAL	ABNORMAL	MUSCULOSKELETAL	NORMAL	ABNORMAL
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			Neck		
Eyes/Ears/Nose/Throat: Pupils Equal Hearing			Back		
Lymph nodes			Shoulder/Arm		
Heart: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)			Elbow/Forearm		
Pulses: Simultaneous femoral and radial pulses			Wrist/Hand/Fingers		
Lungs			Hip/Thigh		
Abdomen			Knee		
Genitourinary (males only)			Leg/Ankle		
Skin: HSV: Lesions suggestive of MRSA, tinea corporis			Foot/Toes		
Neurologic			Functional Duck Walk		

RECOMMENDATIONS: _____

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities NOT crossed out below.

BASEBALL – BASKETBALL – BOWLING – COMPETITIVE CHEER – CROSS COUNTRY – FOOTBALL – GOLF – GYMNASTICS – ICE HOCKEY
LACROSSE – SKIING – SOCCER – SOFTBALL – SWIMMING/DIVING – TENNIS – TRACK & FIELD – VOLLEYBALL – WRESTLING

EXAMINER

Name of Examiner (print/type): _____ Date: _____

Signature of Examiner: _____ (Check One): ❑ MD ❑ DO ❑ PA ❑ NP

- (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) -

EMERGENCY INFORMATION: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

Student: _____ Grade: _____ Doctor: _____ Phone: (_____)_____

IN EMERGENCY (1): _____ Home #: (_____)_____ Cell #: (_____)_____

IN EMERGENCY (2): _____ Home #: (_____)_____ Cell #: (_____)_____

Drug Reactions: _____ Current Medications: _____

Allergies: _____

michigan high school athletic association

PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE

Shaded headline areas are to be completed by student, parent/guardian or 18-year-old

There are **FOUR** (4) signatures on this page (4) to be completed by student, parent/guardian and/or 18-year-old

A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

Student Name: _____
LAST FIRST MIDDLE INITIAL

Student Address: _____
STREET CITY ZIP

Gender: ☐ M ☐ F Age: _____ Date of Birth: _____ Place of Birth (City/State): _____

School: _____ Circle Grade: **6 7 8 9 10 11 12**

Father/Guardian Name: _____

Phone (home): _____ (work): _____ (cell): _____

Mother/Guardian Name: _____

Phone (home): _____ (work): _____ (cell): _____

Email Address: Parent/Guardian/18-Year-Old: _____

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, **I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements.**

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: **that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume;** and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

(1) Signature of **STUDENT**: _____ Date: _____

(2) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: ☐ YES ☐ NO

If YES, Family Insurance Co: _____ Insurance ID #: _____

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

(3) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____

- (DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE) -

MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, _____, an 18-year-old, or the parent or guardian of _____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

(4) Signature of **PARENT** or **GUARDIAN** or **18-YEAR-OLD**: _____ Date: _____

Cherry Health

Student Sliding Fee Program Application

The Sliding Fee Program allows patients to receive care at a reduced cost. Even if you have insurance, you should apply for the Sliding Fee Program. The information that you provide on this form is **confidential.**

Patient information

Patient name _____ Date of birth _____

Social security number _____ Phone number _____

Address _____

Do you currently have Medicaid or Medicare? Yes No

Other Insurance name _____ Insurance phone number _____

Subscriber name _____ Subscriber date of birth _____

Policy number_____

The information that I have provided is correct to the best of my knowledge. I attest that I am not employed and have $0 income.

Patient Signature **Date**

For Internal Use Only

Documentation Yes Pending No documented income _____

Sliding Fee qualification: B – 100% C – 75% D – 50% E – 25%

Staff Signature Date Date entered in computer

Rev 11/2/22
Form #13021Psp
Scan to Financial

Cherry Health

Solicitud de estudiante para el Programa de Tarifas Basadas en el Ingreso

El Programa de tarifas basadas en el ingreso permite a los pacientes recibir atención a un costo reducido. Aunque tenga seguro médico, debe solicitar el Programa de tarifas basadas en el ingreso. La información que proporcione en este formulario es **confidencial**.

Información del paciente

Nombre del paciente_____ Fecha de nac. _____

Número de Seguro Social _____ Teléfono _____

Dirección _____

¿Tiene actualmente Medicaid o Medicare? Sí No

Otro nombre del seguro_____ Teléfono del seguro_____

Nombre del suscriptor _____ Fecha de nac del suscriptor _____

Número de póliza_____

La información que proporcioné es correcta a mi leal saber y entender. Entiendo que tengo que informar todo cambio en mis ingresos en un plazo de 30 días posteriores a que ocurra. Cherry Health revisará cada 12 meses si reúno las condiciones, dependiendo del comprobante de ingresos que presente.

Firma del estudiante **Fecha**

Solo Para Uso Interno

Documentation Yes Pending No documented income _____

Sliding Fee qualification: B – 100% C – 75% D – 50% E – 25%

Staff Signature Date Date entered in computer