Salinas Valley HEALTH

MOBILE CLINIC

Patient Information:

Last Name:	First Name:	Middle Initial:	
Gender:	Social Security#: - -	Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other	
Birthdate: / /	Race:	Ethnicity:	Primary Language:
Mailing Address:	City:	State:	ZIP:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	
By providing my cell phone number, I consent to Salinas Valley Health, including its business associates, calling and/or texting regarding appointments and to call regarding my care and/or payment of my care. Other federal and state rules govern telemarketing and commercial email messages. A summary of these laws is available on the website of the Office of the Attorney General at oag.ca.gov/privacy/privacy-laws.			
Email Address (Required):			
Preferred Pharmacy:	City:	Street:	
Name of your Primary Care Physician:			

If Patient Is A Minor Please Complete:

Name of Parent/Guardian:		Guarantor Date of Birth:	
Mailing Address:	Zip:	City:	State:
Social Security#: / /	Relationship to Patient:	Phone: ( )	

Person to Notify in Case of Emergency:

Name :		
Street Address:	City:	Zip:
Home Phone: ( )	Relation to Patient:	

Please describe your illness/injury/symptoms and date of onset: _____

_____ **Work Related:** Yes ____ No ____

Prescriptions

Salinas Valley Health and affiliates, in compliance with the California Business and Professions Code, hereby notify you of your right to either have your prescription filled by our medical provider or of obtaining a written prescription for filling at a pharmacy of your choice. Please advise the prescribing provider if you elect NOT to have your prescription filled and a written prescription will be provided to you.

Patient email Address

By providing my email address, I give Salinas Valley Health permission to email me directly or through a third party to survey me regarding my visits for the purpose of patient satisfaction and quality assessment. Salinas Valley Health will not share my email address or medical records with others.

Lab Service Disclosure

Please be advised that Laboratory Services are provided by Foundation Laboratory, Salinas Valley Health Medical Center Laboratory, and/or another outside laboratory. If you wish to select a laboratory other than the ones mentioned, please inform the medical staff. The lab that receives your specimen(s) will bill you separately for its services.

Signature: _____ **Relationship:** _____ **Date:** _____

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MOBILE CLINIC

Provider Office Consent for Treatment

I hereby consent to any medical or surgical treatment for myself or for my minor child. I understand that even simple treatment or diagnostic measures have a risk of complications, which will be explained at the time of the procedure or treatment. Salinas Valley Health Mobile Clinic staff will assist with referrals for specialized services.

I understand and give my consent to be diagnosed and treated by a licensed Physician Assistant or Nurse Practitioner instead of a Physician. *I also understand that a Physician Assistant or Nurse Practitioner may prescribe and/or dispense my medicines.*

Patient Name: _____

Date of Birth: _____

Patient's Signature:_____
(If Minor, Legal Guardian Signature)

Date: _____

NOTIFICATION TO CONSUMERS:

Physician Assistants (PA) are licensed and regulated by the Physician Assistant Board, (916) 561-8780, www.pab.ca.gov

Nurse Practitioners (NP) are licensed and regulated by the Board of Registered Nursing, (916) 322-3350, www.rn.ca.gov

SALINAS UNION HIGH SCHOOL DISTRICT
431 W. ALISAL ST, SALINAS, CA 93901

SCHOOL: _____ STUDENT I.D.# _____

PREPARTICIPATION PHYSICAL FORM

NAME_____SEX_____ AGE_____ DATE OF BIRTH _____

GRADE_____SPORTS _____

Personal Physician _____Physician's Phone Number _____

Explain "Yes" answers below:	Yes	No
1. Have you ever been hospitalized?	☐	☐
2. Have you ever had surgery?	☐	☐
3. Are you presently taking any medications or pills?	☐	☐
4. Do you have any allergies (medicine, bees, or other stinging insects)?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
6. Have you ever been dizzy during or after exercise?	☐	☐
7. Have you ever had chest pain during or after exercise?	☐	☐
8. Do you tire more quickly than your friends during exercise?	☐	☐
9. Have you ever had high blood pressure?	☐	☐
10. Have you ever been told that you had a heart murmur?	☐	☐
11. Have you ever had racing of your heart or skipped heartbeats?	☐	☐
12. Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
13. Do you have any skin problems (itching, rashes, acne)?	☐	☐
14. Have you ever had a head injury?	☐	☐
15. Have you ever been knocked out or unconscious?	☐	☐
16. Have you ever had a seizure?	☐	☐
17. Have you ever had a stinger, burner or pinched nerve?	☐	☐
18. Have you ever had heat or muscle cramps?	☐	☐
19. Have you ever been dizzy or passed out in the heat?	☐	☐
20. Do you have trouble breathing or do you cough after your activity?	☐	☐
21. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	☐	☐
22. Have you had any problems with your eyes or vision?	☐	☐
23. Do you wear glasses, contacts or protective eye wear?	☐	☐
24. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of the following bones or joints? Mark all that apply	☐	☐
☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Knee ☐ Chest ☐ Hip ☐ Forearm ☐ Shin/Calf ☐ Back ☐ Wrist ☐ Hand ☐ Foot		
25. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?	☐	☐
26. Have you had a medical problem or injury since your last evaluation?	☐	☐

27. When was your last tetanus shot? …… _____
28. When was your last measles immunization? _____
29. When was your last menstrual period? _____
30. When was your first menstrual period? …… _____
31. What was the longest time between your periods last year? _____

Explain "Yes" answers: _____

_____

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

Signature of Student_____Signature of Parent_____
Date_____Date_____

Adapted from Lombardo et al. *Preparticipation Physical Evaluation* (monograph). Kansas City, MO; American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, American Osteopathic Academy of Sports Medicine, 1992.

NAME OF STUDENT _____

PHYSICAL EXAMINATION

Height _____ Weight_____ Blood Pressure_____/_____ Pulse_____

Vision: Right 20/____ Left 20/_____ Corrected: Yes No Pupils_____

	Normal	Abnormal Findings				Initials
Tanner Stage	**1**	**2**	**3**	**4**	**5**	
Cardiopulmonary						
Pulses						
Heart						
Lungs						
Abdominal						
Genitalia						
ENT						
Skin						
Musculoskeletal						
Neck						
Shoulder						
Elbow						
Wrist						
Hand						
Back						
Knee						
Ankle						
Foot						
Other						

CLEARANCE:

- ☐ Cleared
- ☐ Cleared after completing evaluation/rehabilitation for: _____
- ☐ Noncontact _____Strenuous _____Moderately strenuous _____Nonstrenuous

Due to: _____

Recommendation: _____

_____

_____

Physician's Signature: _____Exam Date: _____
Address: _____Phone: _____

Physician's Stamp:

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