Sports Physical Registration Form

Date of Physical: 5/1/26

Patient Name: _____ MRN: _____

Patient Demographics:

Sex: _____ DOB: ____/____/____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Language: _____

Ethnic Group: _____ Race: _____

PCP: _____ Pharmacy: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Emergency Contact Relationship: _____

Guarantor (Guardian) Information:

Guarantor Name: _____ Relation to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ Sex: _____ DOB: _____/_____/_____

Guarantor (Guardian) Employer Information:

Employer Name: _____ Status: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Employer Phone: _____

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☐ Carle Foundation Hospital
☐ Carle Physician Group
☐ Carle Hoopeston Regional Health Center
☒ Carle Richland Memorial Hospital
☐ Carle BroMenn Medical Center
☐ Carle Eureka Hospital
☐ Carle West Physician Group
☐ Carle Methodist Hospital
☐ Carle Pekin Hospital
☐ Carle Proctor Hospital

UNIVERSAL CONSENT

CONSENT

Patient Name: _____

Date of Service: 5/1/24 MRN: _____ DOB: _____

Throughout this document, the reference to "Carle" collectively refers to Carle Health and its hospitals and providers. For a listing of all Carle locations and providers, please visit www.carle.org or call our main number at 217-383-3311. You must sign this form prior to receiving treatment except in the case of an emergency.

CONSENT FOR TREATMENT AND GENERAL ACKNOWLEDGMENTS

- I consent to the provision of care, diagnostic procedures, laboratory testing and medical treatment as my physician(s) and/or other healthcare provider(s) deem necessary. If surgery, complex diagnostic, therapeutic procedures and/or blood or blood products are required, my practitioner will discuss these with me and additional informed consent may be obtained. I understand that there are no warranties or guarantees regarding the services and care provided.
- Some care may be provided using telehealth technology and I consent to participate in telehealth consultations.
- I consent to the taking of photographs or video recordings that document conditions, treatments or procedures and understand that such images may be used for medical, research or teaching purposes. I understand that I am not allowed to take pictures or make video or audio recordings of my care, other patients, Carle employees, providers, or students in Carle facilities.
- Information I provide regarding religious affiliation will be available to clergy affiliated with my congregation unless I indicate otherwise to admission staff.
- I understand that Carle's mission includes research to advance knowledge and medical breakthroughs. I understand that Carle may use or share my excess body tissue or body fluid for educational and research purposes in accordance with law. If my specimen(s) or other material(s) are provided to third parties, the specimen(s)/material(s) will be made anonymous.
- I understand that the providers participating in my care, including my physician, may be either employees of Carle or independent contractors who are not employees or agents of Carle, but are permitted to use Carle facilities for the care and treatment of their patients.
- I understand that as a teaching institution, medical residents and clinical students may participate in my care unless I request otherwise. I understand that if I refuse a medical student or resident, I must communicate my preference to my healthcare provider at the time of treatment. Carle will attempt to honor the request to exclude a resident or clinical student where feasible and if such exclusion will not be detrimental to my healthcare.
- I understand that Carle will not be responsible for the loss, destruction, or theft of any personal property that I bring with me to Carle. I take full responsibility and release Carle from any responsibility or liability for my personal property.
- I acknowledge that Carle uses video surveillance throughout its facilities to ensure a safe and secure environment for patient, visitors, and staff.

RELEASE AND SHARING OF RECORDS

I understand Carle may share records, charts, x-rays, laboratory work or similar information regarding my medical care with other Carle entities for the purposes of my treatment. Carle may release any medical records related to this medical visit to other providers who participate in my care. I acknowledge that Carle shares its electronic medical record system with other healthcare entities through the Community Connect program. When I am treated by practitioners using this combined system, those individuals will have access to my medical information and use the same medical record system to document information about care and services for purposes of continuity of care. Once my information is combined, it cannot be separated. I understand and acknowledge that federal and state laws require certain medical conditions/diseases to be reported to government agencies. Such conditions/diseases include HIV/AIDS and sexually transmitted diseases.

NOTICE OF OBSERVATION STATUS

Should you be admitted to a Carle facility as an "inpatient," your admitting provider may change that status to "observation" following a review of your medical needs. That change in status may impact your insurance coverage under the federal Medicare program, the medical assistance program under Article V of the Illinois Public Aid Code, or your commercial insurance policy for the current hospital stay, including medications and other pharmaceutical supplies, as well as coverage for any subsequent discharge to a skilled nursing facility, home, or community based care. We encourage you to contact your insurance company to better understand the implications of being placed into the "observation" status.

ASSIGNMENT OF INSURANCE BENEFITS AND INSURANCE COMMUNICATIONS

I authorize Carle to bill my insurance(s) directly whether that insurance is identified by Carle or by me before or after care is rendered. I authorize my insurance(s) to make payments directly to Carle for all services provided, but not exceeding the charges due. I give Carle permission to communicate with my insurance companies and/or state agencies on my behalf to assist with managing my rights and benefits.

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CONSENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES

I have been provided a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities, made available to me as a handout or as part of the Patient Registration and Admitting Information Booklet.

PAYMENT AGREEMENT

I assume full responsibility for and agree to pay all costs, charges and expenses incurred by me for the medical care provided by Carle, whether as an inpatient or outpatient. If my insurance coverage or qualifying financial assistance and/or charity care is not sufficient to satisfy such costs, charges and expenses in full, or I do not follow guidelines of my insurer and the resulting balance is not covered, I will be fully responsible for payment of this balance when allowed by law and/or insurance contracts.

CONSENT TO RECEIVE EMAIL COMMUNICATIONS AND AUTO-DIALED MESSAGES/CALLS

I consent to receive auto-dialed and/or artificial or pre-recorded message calls and/or text messages to my phone number and any other telephone number that I have provided or will provide or that is available to Carle from third parties, including my wireless(s) numbers. I authorize Carle and/or their affiliates and agents, including without limitation, any account management companies, debt collectors, appointment reminder software, and/or general messaging services to use automated dialing technology and pre-recorded messages, phone calls or texts even if I am charged for the call or text under my phone plan. I agree that any such contact is not considered "unsolicited" for purposes of local, state, or federal law. By providing Carle with my email address, I consent to receive email communication concerning my treatment and obligations including any disclosures required by federal or state law. Such disclosures include those required of the Electronic Funds Transfer Act and Regulation E, the federal Fair Debt Collection Practices Act, the federal Telephone Consumer Protect Act and any other applicable federal, state, or local law. Email communication may come from Carle and/or their affiliates and agents including collection agents and service providers. The communication may include document attachments or links to documents which can be printed or saved to your personal device. This consent will not expire and applies to any and all Carle encounters whether previously created or which will be created in the future. I can revoke this consent only by notifying Carle in writing.

ILLINOIS FAIR PATIENT BILLING ACT

Depending on the services I receive today, I understand that I may receive separate bills for services provided by Carle providers or other providers outside Carle who provide health care services. Further, I understand that some health care providers may not be participating providers with the same insurance plans and networks as Carle. As a result, I understand that I may have a greater personal financial responsibility for services provided by health care professionals who are not under contract with my health plan. I understand that questions about my coverage or benefit levels should be directed to my health insurance carrier. I may contact a Customer Service Representative at (888) 712-2753 or (888) 71-Carle with any questions about my bill. I understand that Carle will use automated processes based on information I provide to Carle to determine my eligibility for financial assistance offered by the hospital, public health insurance programs, or other discounted care known to Carle. I consent to such screening process at the earliest reasonable moment for potential eligibility.

RELEASE AND WAIVER

I understand that some healthcare professionals providing services are not employees or agents of Carle. These individuals wear a unique identification badge issued by Carle with the name of their employer and/or a badge issued by their own employer with that company's logo. Independent, non-employed medical providers have been granted permission to provide medial care and treatment to his/her patients at Carle. As such, independent, non-employed providers are not subject to the supervision or control of Carle. I also understand that independent practitioners may bill separately for their services.

NOTICE OF INDEPENDENT PRACTITIONERS

- I acknowledge and understand that there will be physicians, consultants, surgeons, hospital-based physicians (such as pathologist, radiologists, emergency physicians, anesthesiologist, and hospitalists), non-physician providers (such as CRNAs, nurse practitioners, and physician assistants), and surgical vendor representatives, who provide services at CARLE HEALTH PROCTOR HOSPITAL and CARLE HEALTH PEKIN HOSPITAL and who are not employees or agents of CARLE HEALTH PEKIN HOSPITAL CARLE HEALTH PROCTOR HOSPITAL, but instead are independent medical practitioners or contractors ("Independent Practitioners").
- I understand that these non-employed Independent Practitioners exercise their own independent medical judgment, and that they are solely responsible for the care, treatment, and services that they order, request, direct, or provide.
- I acknowledge that these non-employed Independent Practitioners are not subject to the supervision or control of CARLE HEALTH PROCTOR HOSPITAL or CARLE HEALTH PEKIN HOSPITAL, and that the employment or agency status of physicians and other providers who treat me is not relevant and will not affect my selection of CARLE HEALTH PROCTOR HOSPITAL or CARLE HEALTH PEKIN HOSPITAL for my care.
- I acknowledge that any questions about the Independent Contractor Disclosure form and the important information contained in it have been answered to my satisfaction.

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CONSENT

ACKNOWLEDGMENT AND UNDERSTANDING

I understand this consent will expire (1) year from the date the document is signed unless otherwise specified. I acknowledge that this consent applies to all patient encounters with Carle Health prior to the expiration of this consent. I understand that Carle cannot honor any changes that I make to this document. I have read (or had read to me) and understand the above information and agree to its content.

Signature of Patient or Authorized Person	*Date*	*Time*
Signature of Witness	*Date*	*Time*

INTERPRETER SERVICES

I have provided interpretation in _____ *(type of language)* of any verbal and/or written information, including this consent form, that have been provided to the patient/authorized person to consent.

Interpreter Name (print full name)	*Badge #*	*Date*	*Time*
Signature (or if remote source, indicate company used)			

Carle Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, gender identity and sex characteristics) or ability to pay. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-217-383-2543. UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-217-326-0340. 1223CW

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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?
   - 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 Form).

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

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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: _____

_____

_____

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