

School & Sport Physicals offered by the Whiteside County Health Department

(Illinois Requires: Kindergarten, 6th grade, 9th grade Freshman and all Sports)



Eastland High School

June 24, 2026

8:30 - 3:30

Cost for Sports Physical \$35. Cost for School Physical \$50. (Cash, credit card, insurance, Medicare, & Medicaid). Please have all forms completely filled out indicating which physical you are requesting and consent form signed by a legal guardian prior to arrival. Children under 14 years of age must be accompanied by a parent or legal guardian, or with parent/guardian signed consent the child may be accompanied by an adult 18 or older. Children 14-17 do not need to be accompanied by an adult, but must have parent/guardian signed consent form. **NO EXCEPTIONS.** Immunizations will not be given at the event. If your child is due for immunizations, dental, or vision you can call to schedule that appointment at the Health Department. Please call the **Whiteside County Health Department at 815-626-2230 EXT: 1241 or 1215 (no walk-ins).** We hope to see you there!



☒ 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: 1300 West 2nd Street, Rock Falls, IL 61071 Phone: _____

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

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____



■ 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		Yes	No
(If you are unsure of the answer, circle the question, and you don't know the answer.)			
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?			



PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

EXAMINATION			
Height:	Weight:		
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N	
		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), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis			
Neurological			
		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, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: 1300 West 2nd Street, Rock Falls, IL 61071 Phone: _____

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

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WHITESIDE
 COUNTY
HEALTH
DEPARTMENT

Main Office: 1300 W. 2nd St.
Rock Falls, IL 61071
Phone: 815-626-2230
Fax: 815-626-2231

Environmental Office: 18819 Lincoln Rd.
Morrison, IL 61270
Phone: 815-772-7411
Fax: 815-772-4723

Consent to Treat a Minor (14 years of Age and Under)
Without a Parent or Guardian Present

Date: _____

Patient Name: _____

Patient Date of Birth: _____

Name of Parent/Legal Guardian: _____

Telephone Number of Parent/Legal Guardian: _____

I _____ consent for _____ to obtain a school/sports
(Parent/Guardian) (Student)
physical in the presence of _____
(Must be 18 years or Older)

Signature _____
(Adult Listed Above)

_____ Date

Signature _____
(Parent/Guardian)

_____ Date

Patient Information (PLEASE PRINT)

Patient Information 4/1/20

PATIENT'S PREFERRED NAME: _____

Legal Name: _____

Date of Birth: _____

Pronoun: He She They Other _____

Patient's SSN: _____ (photo I.D. required) Phone #: _____

Email: _____

What name would you like to be called in the		
Waiting Room	Preferred	Legal
Exam Room	Preferred	Legal
Phone Calls	Preferred	Legal

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Gender Assigned at Birth (circle one): Male/Female

Gender Identity (circle one): Male /Female /Transgender MTF/Transgender FTM/ Decline/Other: _____

Sexual Orientation (circle one): Lesbian/Gay/ Straight/Bi-sexual / Don't Know/ Decline/Other: _____

Ethnicity (circle one): Mexican, Mexican American, or Chicano Puerto Rican Cuban
Another Hispanic, Latino/a, or Spanish Origin Not Hispanic, Latino/a, or Spanish Origin

Race: Asian Indian Chinese Filipino Japanese Korean Vietnamese Native Hawaiian Other Pacific Islander
Guamanian or Chamorro Samoan Black/African American American Indian/Alaska Native White More than one Race

Are you a migrant or seasonal farm worker? Y/N

Are you homeless (e.g. staying with others, in a hotel, in a shelter, living outside, or in a car (Y/N)

Do you require an interpreter? Y/N

Are you a U.S. Veteran? Y/N

Emergency Contact Information

Name: _____ Relationship: _____ Phone #: _____

Guardian/Guarantor Information (To be completed by person responsible for this account.)

Person's name responsible for this account (if other than patient listed above): _____

Relationship to patient (circle one): Parent Partner Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of birth of person responsible for this account: _____

FINANCIAL AGREEMENT: I hereby assign Whiteside County Community Health Clinic (WCCHC) all my rights, title and interest to reimbursement under any Medicare, Medicaid, or other insurance policies for which benefits may be available for payment of services provided. I sign as an agent, patient, or as "guarantor" that I understand my insurance company will be billed for services I receive at the WCCHC, and that I am directly responsible and agree to pay the WCCHC the balance due of all charges that may not be covered by my insurance. This may include the cost of collection and/or reasonable attorney's fees. I understand that any labs collected by the WCCHC and performed by an outside lab (LabCorp) will be billed separately to my insurance by LabCorp. I give my direct consent and express consent and permission to the clinic or business associates of the clinic to receive account communications, through various means such as 1) any cell, landline, or other phone number that I provide, 2) auto dialer systems, 3) voicemail messages, 4) text messages 5) emergency contact information, 6) pre-recorded forms of voice messaging systems. This information will not be sold.

Name: _____ Signature: _____ Date: _____

Whiteside County Community Health Clinic
Health History

Patient Sticker

Provider History

Physician/NP/PA: _____ Last Visit: _____
Dentist: _____ Last Visit: _____
Optometrist: _____ Last Visit: _____
Therapist: _____ Last Visit: _____

Health History					
Condition	Self	Family History (Mother, Father, Brother, Sister ONLY)	Condition	Self	Family History (Mother, Father, Brother, Sister ONLY)
Anxiety	☐	☐	Cancer: _____	☐	☐
Depression	☐	☐	Radiation Therapy: Head/Neck	☐	☐
ADHD	☐	☐	Sleep Apnea	☐	☐
Bipolar Disorder	☐	☐	Use a CPAP Machine	☐	☐
Schizophrenia	☐	☐	Epilepsy/Seizure Disorder	☐	☐
Autism Spectrum Disorder	☐	☐	High Blood Pressure	☐	☐
Blindness	☐	☐	Stroke: Date: _____	☐	☐
Cerebral Palsy	☐	☐	High Cholesterol	☐	☐
Deafness	☐	☐	Bleeding/Clotting Disorder	☐	☐
Intellectual Disability	☐	☐	Blood Clot in Leg or Lung	☐	☐
Diabetes Type I	☐	☐	HIV/AIDS	☐	☐
Diabetes Type II	☐	☐	Sexually Transmitted Infection	☐	☐
GERD/Acid Reflux	☐	☐	Asthma	☐	☐
Stomach/Intestinal Disorder	☐	☐	COPD/Emphysema/Lung Dis.	☐	☐
Ulcer	☐	☐	Glaucoma	☐	☐
Eating Disorder	☐	☐	Arthritis	☐	☐
Hepatitis Type: _____	☐	☐	Osteoporosis	☐	☐
Other Liver Disease: _____	☐	☐	Urinary Problems	☐	☐
Kidney Disease: _____	☐	☐	Other: _____	☐	☐
Thyroid Disease: _____	☐	☐	Other: _____	☐	☐
Heart Conditions (SELF ONLY)					
Artificial Valve	☐		Rheumatic Heart Disease/Fever	☐	
Previous Infective Endocarditis	☐		Congenital Heart Disease (CHD)	☐	
Heart Transplant	☐		☐ Unrepaired, Cyanotic CHD		
Heart Murmur	☐		☐ Repaired (Completely) in Last 6 Months		
Pacemaker	☐		☐ Repaired CHD with Residual Defects		
Other: _____	☐		Other: _____	☐	
Tobacco/Nicotine Use					
Are you a current tobacco/nicotine user? Yes No If no, continue to the back page.					
How many packs per day do you currently use: Less than 1 pack 1 pack per day 2 packs per day					
Do you currently use smokeless tobacco/nicotine products? Yes No					

Continue to Back

Surgical/Hospitalization/Serious Injury History	
Total Joint Replacement (hip, knee, shoulder, etc) Date(s): _____ Hospital/Location: _____ Any Complications: _____	
Other Surgeries/Hospitalizations/Serious Injury Date(s): _____ Hospital/Location: _____ Any Complications: _____	
Other Surgeries/Hospitalizations/Serious Injury: _____ Date(s): _____ Hospital/Location: _____ Any Complications: _____	
Health Screenings (If Applicable)	
Colorectal Cancer Screening Date: _____ Cervical Cancer Screening Date: _____	Breast Cancer Screening Date: _____ Hgb A1C (Diabetes) Date: _____
Men's Health	
PSA/Rectal Exam: Date: _____	Do you Perform Self Testicular Exams? Yes or No
Women's Health (12 Years Old and Up)	
1 st Menstrual Period – Age: _____ Last Menstrual Period Date: _____ Menopause Year: _____ Are you currently Pregnant: Yes or No Estimated Due Date: _____ OB History: Pregnancies: _____ Living Children: _____ Miscarriages/Abortions: _____ Birth Control: ☐ None ☐ Pills ☐ Other: _____ Do you Perform Self Breast Exams? Yes or No Currently Nursing? Yes or No	
Medication History	
☐ Currently taking, previously taken, or scheduled to begin taking medications for osteoporosis: Alendronate (Fosamax), Ibandronate (Boniva), Risedronate (Actonel), Denosumab (Prolia), or Reclast? ☐ Currently taking or scheduled to begin treatment with IV bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia, multiple myeloma or metastatic cancer? Date treatment began: _____ ☐ Currently taking blood thinners (Coumadin/Warfarin, Plavix, Brilinta, Xarelto, Eliquis, Pradaxa, etc)	
Current Medications	
☐ NONE ☐ Medication List Attached	
Allergies and Reactions	
☐ NONE	

I hereby certify that the information provided in this form is complete, true and correct to the best of my knowledge.

Patient/Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____