PSMC Sports Physicals
Friday, May 9
2:00pm-4:30 pm

CASH ONLY
$26

Who We Play For
athlete cardiac screenings
FREE

Please complete the following forms and bring to the exam at PSMC Clinic
95 S. Pagosa Blvd.

WHO WE PLAY FOR HEART SCREENING

For Every Kid Who Never Had The Opportunity

An Electrocardiogram (ECG or EKG) is painless, non-invasive and only takes 5 minutes to complete.

Each ECG is read by a board certified pediatric cardiologist.

WHEN: Friday, May 9th from 2pm - 4:30pm

WHERE: Pagosa Springs Medical Center Primary Care Clinic

(95 S Pagosa Blvd - 2nd Floor)

COST: Free for Students Ages 11 - 25

REGISTER: Online at https://www.whoweplayfor.org/colorado-archuleta

To learn more about Who We Play For or to get involved, visit whoweplayfor.org

80%
No symptoms prior to Sudden Cardiac Arrest event

1 IN 300
Youth have a detectable heart condition

 # 1
Cause of death on school campuses and in student athletes

Patient Demographics

Patient's Name: _____ Previous or Nickname: _____

Sex: ☐ Male ☐ Female Social Security Number _____ - _____ - _____ Date of Birth: _____

Physical Address: _____
City State Zip Code

Mailing Address: _____
City State Zip Code

Home Phone #: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No

Cell Phone #: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No

Email Address: _____

Race: ☐ White ☐ Black/African American
☐ American Indian/Alaskan Native
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Unknown ☐ Refuse to Report

Ethnicity: ☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown ☐ Refuse to Report

Marital Status: _____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____ ☐ Refuse to Report

Would you like to receive an email invitation to our patient portal so that you can view your lab results online?
☐ Yes ☐ No

EMERGENCY CONTACT:
Name: _____ Relationship: _____

Home Phone #: (_____) _____ - _____ Additional Phone #: (_____) _____ - _____

Patient Signature: _____ **Date:** _____ / _____ / _____

For Minor Patients Only:

Parent/Legal Guardian's Printed Name: _____

Signature of Person with Authority to Consent: _____

State How Authorized: _____

PAGOSA SPRINGS
Medical Center
THE CARE YOU DESERVE, IN THE MOUNTAINS YOU LOVE

Reviewed/Revised 03/23/2016, 11/04/2016, 3/11/2019, 11/20/2019, 10/9/2023, 2/1/2024

PAGOSA SPRINGS
Medical Center

General Consent for Visit or Admission

CONSENT FOR TREATMENT: I consent to receive care and services from Pagosa Springs Medical Center (PSMC). S ervices may include, but are not limited to, examination, routine diagnostic procedures, assessment, medical and mental health treatment and administration of medications. These services will be provided by the Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Behavioral Health staff, and/or assistants of any such providers. I understand that I have the right to discuss proposed procedures or treatments with my provider. I understand that the practice of medicine is not an exact science, and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the results of examinations or treatments. I understand that this consent covers all procedures not requiring a specific consent and this consent is valid for this visit only.

FINANCIAL POLICIES AND ASSIGNMENT OF BENEFITS: In most circumstances, fees that are your responsibility (co- payments, deductibles, co-insurance) are payable when services are rendered. It is your responsibility to know your own health insurance benefits, including whether PSMC is a contracted provider with your insurance company and your covered benefits, excluded benefits and any pre-authorization requirements. PSMC will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you may be financially responsible. In consideration of the services, you or your guarantor are obligating yourself to pay the charges in full for your visit or procedure. PSMC will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility based on your benefit plan. This process generally takes 45-90 days from the time the claim is received by your insurance company. Your insurance company will make payments directly to PSMC for services provided to you by PSMC, its staff and to non-employed professionals for services provided by them. Some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your financial responsibility may be higher than the In-Network rate. I understand that some of the professionals who provide care to me during my hospital stay are not employees or agents of the hospital. These professionals may include other physicians requested by my physician to participate in my care, as well as radiologists and pathologists. As a result, I understand that these professionals will bill me for charges that are separate from those of the hospital.

HEALTHCARE WORKER EXPOSURE/BLOOD TESTING: If a health care worker is exposed to my blood or body fluids, I consent to laboratory testing to evaluate the worker's risk of contracting Hepatitis B, Hepatitis C or HIV. There will be no charge for this testing.
PERSONAL BELONGINGS: I understand that PSMC will not be liable for loss or damages to my personal property.
LEAVING AGAINST MEDICAL ADVICE: If I choose to leave PSMC against or without the advice of my physician, I hereby release the physician, the health care facility, and its agents and employees from all liability for any ill effects that may result.
RETENTION OF SPECIMENS: When applicable, I authorize PSMC to take, retain, preserve and use for scientific or teaching purposes, or dispose of at its convenience, all specimens, tissues, parts or organs taken from my body during my visit/hospitalization.

ACKNOWLEDGEMENTS: I acknowledge that I have read this form and understand its contents. I further acknowledge that I am the patient, or person duly authorized either by the patient or otherwise (PSMC is not responsible for the consideration of custody arrangements), to sign this agreement, consent to and accept its terms. By signing below, I acknowledge that I have read the following and I am aware that I can request copies of these notices at any time onsite or from the PSMC website. I also understand that PSMC participates in electronic Health Information Exchange (HIE) and I hereby authorize the release of medical records to the HIE in support of my care and as necessary to process claims related to my care.

1. **Notice of Privacy Practices**
2. **Patients' Rights and Responsibilities**
3. **Advance Directives**
4. **No Surprises Billing Disclosure**
5. **Hospital Discounted Care**

Print Patient Name_____ Patient Date of Birth_____

Signature _____ Date & Time: _____
Patient or Patient Representative

If not the patient:

Print Representative Name _____ Date of Birth_____

Authority to Sign _____

Witness_____ Date & Time: _____

* ATHLETE MUST COMPLETE *

PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.

This form is valid for 365 calendar days from the date signed below.

1

Revised 8/24

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Gender: _____ Age: _____ Date of Birth: ___/___/_____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

List past and current medical conditions:

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

Patient Health Questionnaire version 4 (PHQ-4)

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several days	Over half of the days	Nearly everyday
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

	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 illnesses?		
	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?		

	HEART HEALTH QUESTIONS ABOUT YOU *(continued)*	**Yes**	**No**
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
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? (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), Bragada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

* ATHLETE MUST COMPLETE *

PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.

This form is valid for 365 calendar days from the date signed below.

2

Revised 8/24

Student's Full Name: _____ Date of Birth: ___/___/_____ School: _____

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
MEDICAL QUESTIONS		**Yes**	**No**
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
22	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?		
23	Have you ever become ill while exercising in the heat?		
24	Do you or does someone in your family have sickle cell trait or disease?		
25	Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS *(continued)*		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports- related injuries and death. CHSAA bylaw 1780.1 states, "No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until there is a statement on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that: (a) he/she/they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics; and (c) that he/she/they has the consent of his/her/ their parents or legal guardian to participate. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until this form is completed in its entirety and page 4 is on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that: (a) he/she/ they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics. The CHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ *(printed)* Student-Athlete Signature: _____ Date: ___/___/___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___/___/___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___/___/___

* PSMC USE ONLY *

PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)

This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.

This form is valid for 365 calendar days from the date signed below.

3

Revised 8/24

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___/___/_____ School: _____

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?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	
• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?	

☐ Verify completion of Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION			
Height:	**Weight:**		
BP: / (/)	**Pulse:**	**Vision:** R 20/ L 20/	**Corrected:** Yes No

MEDICAL - healthcare professional shall initial each assessment	**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 Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		

MUSCULOSKELETAL - healthcare professional shall initial each assessment	**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		

Name of Healthcare Professional (print or type): _____ Date of Exam: 05/09/2025

Address: 95 S. Pagosa BLVD Phone: 970-731-3700 E-mail: _____

Pagosa Springs CO

81147

* Athlete MUST COMPLETE *
TOP PORTION ONLY

PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT ONLY THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

4

Revised 8/24

Athlete MUST COMPLETE

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Gender: _____ Age: _____ Date of Birth: ___/___/_____
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (_____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

PSMC To Complete

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

_____

I hereby certify that I have examined the above-named student-athlete using the CHSAA Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date of Exam: 05/09/2025
Address: 95 S Pagosa Blvd, Pagosa Springs CO 81147 Phone: 970 731 3700
Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

Parent of Athlete + PSMC To Complete

List any medical history that is relevant to participation in competitive sports. *(explain below, use additional sheet, if necessary)*

_____

_____

_____

☐ Allergies/Anaphylaxis ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait
☐ Mental Health ☐ N/A – No relevant medical information to disclose

Medications: *(use additional sheet, if necessary)*

List: _____

_____

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct.

This form is not considered valid unless all sections are complete.