



SPORTS PHYSICAL EVENT

Where: Pagosa Springs Medical Center

When: Saturday, July 25th, 9am-Noon

Who: Pagosa Springs Medical Center and Who We Play For

What: Sports Physicals for the 2026-2027 School Year for Middle School and High School Students

\$26 Cash Only

Athletes will be seen in the order of arrival. Please have the below items with you and ready at check-in for a better experience.

_____ \$26 Cash

_____ Who We Play For (WWPF) Registration Completed Online before arrival. This is a FREE non-invasive cardiac screening that is HIGHLY recommended. If you were screened last year, you don't need one this year unless you want to.

_____ Who We Play For Consent **MUST be signed by your Parent/Guardian.**

_____ PSMC Demographic form

_____ PSMC Consent Form - **MUST be signed by your Parent/Guardian.**

_____ CHSAA Sports Physical Form – All highlighted portions must be completed and **MUST be signed by your Parent/Guardian.**

_____ Medical Records for known medical history



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:

07/25/2026 09:00 AM - 12:00 PM

WHERE:

95 S. Pagosa Blvd., Pagosa Springs, Colorado, 81147
Pagosa Springs Medical Center Main Entrance

COST:

FREE for ages 10-22 Sponsored by

PAGOSA SPRINGS
Medical Center

REGISTER:

<http://whoweplayfor.org/form-redirect?id=261804834625056>



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

Pagosa Springs Medical Center

Electrocardiogram (“ECG”) Screening Consent Form and Release of Liability



1. About the ECG Screening

An ECG screening (also commonly referred to as an EKG) is a test that measures the electrical activity of the heart to help identify an individual’s risk for sudden cardiac death. ECG screenings performed by Who We Play For (“WWPF”) involve (i) an ECG screening and (ii) a medical history form.

2. Consent to Participate and Acknowledgments

To receive an ECG screening, every Participant must read and sign this Electrocardiogram Screening Consent Form and Release of Liability (“Consent and Release”). If Participant is a minor, Participant’s parent or legal guardian must read and sign this Consent and Release. The individual receiving the ECG Screening will be referred to herein as the “Participant”. By signing this Consent and Release, you acknowledge and attest to the following: • I carefully read this Consent and Release, I understand this Consent and Release, and I have had the opportunity to ask any questions; • I voluntarily consent and elect to have representatives and volunteers perform an ECG screening on Participant;

- I understand and voluntarily assume all risks associated with the Participant's participation in this ECG screening program. I understand that the ECG screening will only screen for abnormalities in Participant's heart and does not constitute a complete medical exam or diagnosis. I understand that abnormal test results do not officially represent or imply that Participant does or does not have a heart condition. I understand that no warranty or guarantee has been made to me as to the results of the screening. I understand that this screening does not diagnose all causes of sudden cardiac death. I acknowledge that the information I receive from the ECG screening reflects the condition of Participant's heart on the day of the ECG screening. This ECG screening does not constitute a conclusive diagnosis of Participant's heart health or physical condition, and is not intended to serve as a replacement for treatment and checkups with Participant's primary care physician or other provider. I acknowledge the limitations of an ECG screening and that sudden cardiac death or other cardiac events may still occur, despite this screening. I understand that this ECG screening does not establish a treatment or provider relationship between (i) Participant and (ii) WWPF or any individual administering, interpreting, or communicating the ECG screening or the ECG screening results. I recognize and acknowledge that I am solely responsible for taking any appropriate follow-up action related to Participant's ECG screening results. I understand that follow-up care and treatment is not a part of this ECG screening program; and
- I have the authority to sign this Consent and Release because either (i) I am the Participant or (ii) I am the parent or legal guardian of Participant.

3. ECG Screenings Results, Communication, and Confidentiality

The board-certified cardiologist that reads and interprets Participant’s ECG screening will place Participant into one of three categories: (i) low risk; (ii) follow-up required; or (iii) higher risk. I acknowledge that any Participant’s ECG screening that is designated as “higher risk” will be required to undergo further testing (e.g., an echocardiogram or ultrasound) prior to being allowed to resume athletics. In certain counties, Participants designated as “follow up required” must undergo further testing prior to being allowed to resume athletics. I acknowledge, understand, and accept the following:

- If the board-certified cardiologist places Participant into a category that requires further testing or medical consultation, then WWPF may inform the individuals that oversee Participant’s involvement in athletics and any medical professionals involved with the physical or medical examination as part of this event of Participant’s ECG screening results and status.
- As part of this ECG screening, I agree to allow (i) medical professionals and (ii) WWPF personnel, contractors, and volunteers (the “WWPF Team”) to have access to the medical records created during this ECG screening. I agree to allow the WWPF Team to contact me regarding Participant’s involvement in this ECG screening and the results. I authorize WWPF to use all information provided, including the ECG screening, for diagnostic and aggregated statistical purposes and evaluations and medical research. The information collected from any ECG screening event may be published in scientific journals or presented at scientific meetings, but no Participant will be personally identified. This authorization may be revoked by submitting a written notice to WWPF at info@whoweplayfor.org. As applicable, the WWPF Team will follow all relevant state and federal laws and regulations, including any applicable sections of the Health Insurance Portability and Accountability Act (HIPAA) and the Family and Education Rights and Privacy Act (FERPA).

4. Waiver & Release of Claims and Liability

By signing this Consent and Release, I hereby agree to waive any and all claims against WWPF and their employees, directors, officers, representatives, sponsors, trustees, partners, consultants, volunteers, and contractors (collectively, the “Indemnified Parties”). I further agree to indemnify, release, and hold harmless the Indemnified Parties from any and all claims, liabilities, cost, and expenses arising out of or related to the performance, interpretation, and/or communication of the results of this ECG screening.

5. Acknowledgment & Preliminary Medical History Questions

I certify that I have read this form or have had it read to me and that I fully understand this Consent and Release. In consideration of the ECG services provided by WWPF to Participant, I consent (i) to this Consent and Release and (ii) to Participant’s involvement in the ECG screening program. I **CONSENT** to Participant participating in the ECG screening. I understand the cost is \$20 for 10 to 24 year-olds. **Note:** Who We Play For may be able to assist families with the cost of this program if they qualify for free lunch and are in financial hardship. If applicable to you, please choose one of the options below:

We can afford a partial donation of \$____. We would appreciate full financial assistance.

Participant’s Name (please print clearly)

Date

Parent/Guardian Name (if applicable) (please print clearly)

Parent/Guardian Signature (Participant’s signature if an adult)

Parent/Guardian Email Address (please print clearly)

Parent/Guardian Phone Number (Participant’s number if an adult)

Note: If you would like to “pay it forward” and donate to cover the cost for a student in financial need, please include the additional donation with your payment or reach out to WWPF either online or at the screening event! ☺

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: _____



General Consent for Visit or Admission

CONSENT FOR TREATMENT: I consent to receive care and services from Pagosa Springs Medical Center (PSMC). Services 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 the hospital 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 the hospital 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 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
6. Service Availability Form

Print Patient Name _____ Patient Date of Birth _____

Signature _____ Date _____ Time _____ AM/PM
Patient or Patient Representative

If not the patient:

Print Representative Name _____ Date of Birth _____

Authority to Sign _____

Witness _____ Date _____ Time _____ AM/PM



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.

Revised 6/25

MEDICAL HISTORY FORM Parent/Athlete to Complete/Sign Pages 1&2, and top/bottom portion of page 4

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

Mental Health Immediate Resources: Colorado Crisis <https://coloradocrisisservices.org/> Call/text 988 or live chat at 988Colorado.com.
 For additional Mental Health Resources, Please go to <https://chsaa.org/sports/2021/7/22/smac.aspx>

GENERAL QUESTIONS		Yes	No	HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.				<i>(continued)</i>			
1	Do you have any concerns that you would like to discuss with your provider?			8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
2	Has a provider ever denied or restricted your participation in sports for any reason?			9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
3	Do you have any ongoing medical issues or recent illnesses?			10	Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
4	Have you ever passed out or nearly passed out during or after exercise?			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)		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			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)?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
7	Has a doctor ever told you that you have any heart problems?						



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.

Revised 6/25

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

Table with columns for BONE AND JOINT QUESTIONS, MEDICAL QUESTIONS, and MEDICAL QUESTIONS (continued). Includes questions 14-25 and a section for explaining 'Yes' answers.

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.

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:

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

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

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



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.

Revised 6/25

PHYSICAL EXAMINATION FORM

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

PHYSICIAN REMINDERS:

Consider additional questions on more sensitive issues.

Table with 2 columns and 4 rows of medical history questions.

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

Table for Medical examination with columns for Normal and Abnormal Findings.

MUSCULOSKELETAL - healthcare professional shall initial each assessment

Table for Musculoskeletal examination with columns for Normal and Abnormal Findings.

Name of Healthcare Professional (print or type): _____ Date of Exam: 05 08/ 2026

Address: 95 S Pagosa Blvd, Pagosa Springs, Colorado Phone: (970) 731-3700 E-mail: N/A

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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.

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: (____) _____

- 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: 05/08/2026
Address: 95 S Pagosa Blvd, Pagosa Springs, Colorado Phone: (970) 731-3700
Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

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

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

Blank lines for listing medical history.

- 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 & signed.

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