Anchorage School Based Health Centers

c/o Christian Health Associates, 1825 Academy Dr., Anchorage AK 99507

907-742-0479

Through ASD Online Registration, you authorized your student to receive medical services through Anchorage School Based Health Centers. Please complete the following information to help ASBHC provide care to your student. Forms can be returned to the school nurse's office or ASBHC Clinic.

Primary Medical Provider/"Medical Home" (if any):

"Release of Information Form" is needed if records need to be sent.

INSURANCE/PAYMENT INFORMATION

We are dedicated to making healthcare affordable and accessible to all students. We accept all insurance plans and welcome Medicaid/Denali Kid Care. Families with incomes below 100% of the federal poverty line will be charged a minimum fee of $10. Families with incomes between 100% and 200% of the federal poverty line will be charged discounted fees based on income. We do not send accounts to collections. No money will be collected from students at the time of services. No one will be denied service based on inability to pay.

CIRCLE Insurance Type:		
Medicaid/Denali Kid Care	Private Insurance	
No insurance/Self Pay	Other	

Insurance ID Number:
Insurance Subscriber's Full Name:
Parent/Insurance Subscriber's Date of Birth:
Patient's relationship to subscriber:
Insurance Company Name
Insurance Company Mailing Address:

Sliding Fee Scale Information

Must be complete to receive sliding fee scale adjustments.

Without it and/or insurance information, you will receive a full bill for the services provided.

Household Size:	Household Income: (circle) Monthly or Annual

Initial Here

I understand there is a fee for the ASBHC services. I acknowledge that the information provided is correct and it will be used to manage my account and process insurance claims. If the services are covered by insurance, I assign all reimbursement for such services to Anchorage School Based Health Centers and request that the insurance company pay the provider directly. If the visit is not covered by insurance, I understand that I am responsible for all fees incurred by my student at ASBHC.

Parent/Guardian Signature:	Date:

More information available online at http://christianhealth.org/school-based-health-centers/

Two sided!

Anchorage School District
Sports Physical - Health Examination Form

MEDICAL HISTORY TO BE COMPLETED BY LEGAL PARENT/GUARDIAN

Last Name (print)_____ First Name _____ Initial_____ Date of Birth _____

1. Have you ever been hospitalized? Y____ N____
2. Have you ever had surgery? Y____ N____
3. Are you presently taking any medications or pills? Y____ N____
4. Have you ever passed out during or after exercise? Y____ N____
5. Have you ever been dizzy during or after exercise? Y____ N____
6. Have you ever had chest pain during or after exercise? Y____ N____
7. Do you tire more quickly than your friends during exercise? Y____ N____
8. Have you ever had high blood pressure? Y____ N____
9. Have you ever been told that you have a heart murmur? Y____ N____
10. Have you ever had racing of your heart or skipped beats? Y____ N____
11. Has anyone in your family died of heart problems or sudden death before age 50? Y____ N____
12. Do you have any skin problems (itching, rashes, acne)? Y____ N____
13. Have you ever had a head injury? Y____ N____
14. Have you ever had a concussion? If yes, how many_____ Y____ N____
15. Have you ever been knocked out or unconscious? Y____ N____
16. Do you suffer from migraines? Y____ N____
17. Have you ever had a seizure? Y____ N____
18. Have you ever had a stinger, burner or pinched nerve? Y____ N____
19. Have you ever had heat or muscle cramps Y____ N____
20. Have you ever been dizzy or passed out in the heat? Y____ N____
21. Do you have trouble breathing or do you cough during or after activity? Y____ N____
22. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc.)? Y____ N____
23. Have you ever had problems with your eyes or vision? Y____ N____
24. Do you wear glasses or contacts or protective eye wear? Y____ N____
25. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? Y____ N____

    ____Head ____Thigh ____Elbow ____Chest ____Shin/calf ____Wrist ____Hip
    ____Shoulder ____Neck ____Knee ____Forearm ____Back ____Ankle ____Hand
26. Have you ever had other medical problems (infectious mononucleosis, diabetes, etc.) Y____ N____
27. Have you had any medical problem or injury since your last evaluation? Y____ N____
28. Are you Diabetic? Y____ N____
29. Are you Asthmatic? Y____ N____
30. Do you have any allergies (medicine, bees or other stinging insects) _____ Y____ N____

    List all allergies: _____
31. When was your first menstrual period? Y____ N____
32. When was your last menstrual period? Y____ N____
33. What was the longest time between your periods last year?
34. Explain all “yes” answers _____

_____

_____

Consent information:

- I hereby consent to emergency treatment, hospitalization or other medical treatment as may be necessary by a physician, qualified nurse, or hospital in the event of an injury or illness.
- I hereby consent to participation in ASAA approved interscholastic activities.
- I hereby consent to travel to and from ASAA activities via school approved transportation.
- I hereby waive on behalf of myself and the above student any liability of the school or ASAA organizationally or for any of its officers, agents or employees for injuries sustained in the interscholastic program.
- I accept financial responsibility for the above student in the event of an injury or illness.
- I hereby state that information submitted on this form is true.
- I hereby consent to abiding by the ASAA rules and regulations and school handbook.
- I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director, coaches and athletic trainers of any interscholastic activities in which I seek to participate.

Student Signature _____ Parent Signature _____Date_____

HEALTH EXAMINATION TO BE COMPLETED BY HEALTHCARE PROVIDER - MD, DO, ANP, PA

Age _____ Height_____Weight _____Blood Pressure _____

Vision R/20 _____ Vision L/20 _____

Circle any of the following that are abnormal and explain under "comments":

Eyes/ears/nose/throat	Genitalia, Tanner stage_____	Knee/hip
PERRLA	Neurological	Back
Respiratory	Skin	Ankles
Cardiovascular	Head/neck	Other musculoskeletal
Liver/spleen/abdomen	LAB: UA, HGB/HCT (as needed)	DT (date): _____

Comments: _____

I certify that on this date, I have examined this student and find him/her physically able to compete in all supervised activities <u>not</u> crossed out:

Baseball	Football	Softball	Wrestling
Basketball	Gymnastics	Swimming	XC running
Bowling	Hockey (boys)	Tennis	XC skiing
Cheer	Hockey (girls)	Track & Field	
Diving	Riflery	Volleyball	
Flag Football	Soccer	Weight Training	

HCP Name (MD, DO, ANP, PA) (print) _____

Signature _____ Date of exam _____

Address _____ **Healthcare provider stamp is required here**

City _____State _____

Phone _____ Zip_____