

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

11 THROUGH 14 YEAR VISITS FOR PARENTS

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? No Yes, describe:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs? No Yes, describe:

Have there been major changes lately in your family's life? No Yes, describe:

Have any of your child's relatives developed new medical problems since your last visit? No Yes Unsure If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? No Yes Unsure

YOUR GROWING AND DEVELOPING CHILD

Check off all the items that you feel are true for your child.

- | | |
|--|---|
| <input type="checkbox"/> My child does things that help her have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping herself safe. | <input type="checkbox"/> My child helps others by himself or by working with a group in school, a faith-based organization, or the community. |
| <input type="checkbox"/> My child has at least one adult in his life who cares about him and knows he can go to if he needs help. | <input type="checkbox"/> My child is able to bounce back when things don't go her way. |
| <input type="checkbox"/> My child has at least one friend or a group of friends who she feels comfortable around. | <input type="checkbox"/> My child feels hopeful and self-confident. |
| | <input type="checkbox"/> My child is becoming more independent and making more decisions on his own as he gets older. |

Please print.

11 THROUGH 14 YEAR VISITS FOR PARENTS

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Has your child ever been diagnosed with iron deficiency anemia?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your family ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If your child is female , does she have excessive menstrual bleeding or other blood loss?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If your child is female , does her period last more than 5 days?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Hearing	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Sexually transmitted infections/ HIV	Adolescents who are sexually active are at risk of sexually transmitted infection, including HIV. Adolescents who use injection drugs are at risk of HIV. Are you concerned that your young adolescent might be at risk?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Tuberculosis	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have trouble with near or far vision?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child ever failed a school vision screening test?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child tend to squint?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Interpersonal Violence (Fighting and Bullying)			
Are there frequent reports of violence in your community or school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Is your child involved in any of the violence?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you think your child is safe in the neighborhood?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Has your child ever been injured in a fight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has your child been bullied or hurt by others?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has your child bullied or been aggressive toward others?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you talked with your child about violence in dating situations and how to be safe?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Living Situation and Food Security			
Do you have concerns about your living situation?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have enough heat, hot water, and electricity?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have appliances that work?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have problems with bugs, rodents, or peeling paint or plaster?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
In the past 12 months, did you worry that your food would run out before you got money to buy more?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
In the past 12 months, did the food you bought not last, and you did not have money to buy more?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

Please print.

11 THROUGH 14 YEAR VISITS FOR PARENTS

YOUR FAMILY'S HEALTH AND WELL-BEING (CONTINUED)

Alcohol and Drugs			
Is there anyone in your child's life whose alcohol or drug use concerns you?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Connectedness With Family and Peers			
Does your family get along well with each other?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you take time to talk with your child every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your child have chores or responsibilities at home?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have clear rules and expectations for your child?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you let your child know when he does something good?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Connectedness With Community			
Does your child have interests outside of school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your child help others at home, in school, or in your community?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
School Performance			
Is your child getting to school on time?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Is your child having any problems at school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Does your child complete homework on time?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Has your child missed more than 2 days of school in any month?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Coping With Stress and Decision-making			
Does your child worry too much or appear overly anxious?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you discussed ways to deal with stress?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you help your child make decisions and solve problems?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

YOUR GROWING AND CHANGING CHILD

Healthy Teeth			
Does your child see the dentist regularly?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have trouble getting dental care?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Body Image			
Do you have any concerns about your child's nutrition, weight, or physical activity?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Does your child talk about getting fat or dieting to lose weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Healthy Eating			
Do you think your child eats healthy foods?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have any difficulty getting healthy food for your family?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have any concerns about your child's eating habits or nutrition?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you eat meals together as a family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Physical Activity and Sleep			
Is your child physically active at least 1 hour a day? This includes running, playing sports, or doing physically active things with friends.	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Are there opportunities to safely play outside in your neighborhood?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you and your child participate in physical activities together?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
How much time does your child spend on recreational screen time each day?	_____ hours		
Does your child have a TV, computer, tablet, or smartphone in his bedroom?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have rules about screen time for your child?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your child have a regular bedtime?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

Please print.

11 THROUGH 14 YEAR VISITS FOR PARENTS

YOUR CHILD'S EMOTIONAL WELL-BEING

Mood and Mental Health			
Is your child frequently irritable?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you noticed any changes in your child's weight or sleep habits?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you and your child often have conflicts about what your culture expects for her behavior and how her friends behave?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have any concerns about your child's emotional health, such as being frequently sad or depressed?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Sexuality			
Have you and your child talked about how his body will change during puberty?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have house rules about curfews, dating, and friends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

HEALTHY BEHAVIOR CHOICES

Sexual Activity			
Have you and your child talked about sex?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you talked about ways to deal with any pressures to have sex?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Substance Use			
Have you talked with your child about alcohol and drug use?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you know your child's friends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you know where your child is and what she does after school and on the weekends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have consequences for your child if you discover he is using tobacco, alcohol, or drugs?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
To your knowledge, is your child currently using alcohol or drugs, or has she used them in the past?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Acoustic Trauma			
Does your child often listen to loud music?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

SAFETY

Seat Belt and Helmet Use			
Do you always wear a lap and shoulder seat belt and bicycle helmet?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you insist your child wears a lap and shoulder seat belt when in a car?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you insist that your child use a life jacket when he does water sports?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Sun Protection			
Does your child use sunscreen?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Gun Safety			
Is there a gun in your home or the homes where your child visits?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you talked with your child about gun safety?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition

For more information, go to <https://brightfutures.aap.org>.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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BRIGHT FUTURES PREVISIT QUESTIONNAIRE

11 THROUGH 14 YEAR VISITS FOR PATIENTS

To give you the best possible health care, we would like to know how things are going. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. **Depression screening (beginning at age 12) and Tobacco, Alcohol, or Drug Use assessment are also part of this visit.** Thank you for your time.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? No Yes, describe:

Blank space for patient response.

TELL US ABOUT YOURSELF.

What are you most proud of about yourself?

Blank space for patient response.

Have there been major changes lately in your family's life? No Yes, describe:

Blank space for patient response.

Have any of your relatives developed new medical problems since your last visit? No Yes Unsure If yes or unsure, please describe:

Blank space for patient response.

Do you live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? No Yes Unsure

GROWING AND DEVELOPING

Check off all the items that you feel are true for you.

- | | |
|---|--|
| <input type="checkbox"/> I do things that help me have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping myself safe. | <input type="checkbox"/> I help others. |
| <input type="checkbox"/> I have at least one adult in my life who I know I can go to if I need help. | <input type="checkbox"/> I am able to bounce back when life doesn't go my way. |
| <input type="checkbox"/> I have a friend or a group of friends that I feel comfortable to be around. | <input type="checkbox"/> I feel hopeful and confident. |
| | <input type="checkbox"/> I am becoming more independent and I make more of my own decisions. |

11 THROUGH 14 YEAR VISITS FOR PATIENTS

RISK ASSESSMENT

Anemia	Does your diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	For girls: Do you have excessive menstrual bleeding or other blood loss?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	For girls: Does your period last more than 5 days?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Dyslipidemia	Do you smoke cigarettes or use e-cigarettes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about how well you see?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you and your family?

HOW YOU ARE DOING

Interpersonal Violence (Fighting and Bullying)			
Have you been part of a gang or a group that has gotten or could get into trouble?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you been in a fight in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you know anyone in a gang?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have ways that help you deal with feeling angry?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you feel safe at home?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you ever been bullied in person, on the Internet, or through social media?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you been in a relationship with a person who threatened you physically or hurt you?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been touched in a way that made you feel uncomfortable?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has anyone touched your private parts without your agreement or against your wishes?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been forced or pressured to do something sexually that you didn't want to do?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Connectedness With Family and Peers			
Do you spend time talking with your parents every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do your parents praise you when you do something good or learn something new?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you get along with your family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have an adult you feel connected to?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have rules at home and know what happens when you break the rules?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Connectedness With Community			
Do you have activities or things you like to do after school or on the weekends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you help others at home, in school, or in your community?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
School Performance			
Are you doing well at school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have things you enjoy doing at school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Are you having any problems in school? Are there things you need help figuring out?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you get extra help or support in any subjects at school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Coping With Stress and Decision-making			
Do you worry a lot or feel overly stressed out?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have things you do to feel better when you are stressed?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS

YOUR GROWING AND CHANGING BODY

Healthy Teeth			
Do you brush your teeth twice a day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you see the dentist twice a year?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
If you play contact sports, do you wear a mouth guard?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Body Image			
Do you have any concerns about your weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Are you teased about your weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Are you currently doing anything to try to gain or lose weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Healthy Eating			
Do you have healthy food options at home and in school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you eat fruits and vegetables every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have milk, yogurt, cheese, or other foods that contain calcium every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you drink juice, soda, sports drinks, or energy drinks?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you ever skip meals?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you eat meals together with your family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Physical Activity and Sleep			
Are you physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
How much time every day do you spend watching TV, playing video games, or using computers, tablets or smartphones (not counting schoolwork)?	_____ hours		
Do you get 8 or more hours of sleep each night?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have trouble sleeping?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

EMOTIONAL WELL-BEING

Do you and your parents argue a lot about what your culture expects of you and what your friends are doing?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you talked with your parents about dating and sex?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have questions or concerns about how your body is changing (puberty)?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
For girls: Have you started your period?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
For girls: If yes, do you have any concerns about your period (such as not regular, heavy bleeding, or bad cramping)?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

HEALTHY BEHAVIOR CHOICES

Romantic Relationships			
Have you ever been in a romantic relationship?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If yes, have you always felt safe and respected?	<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> Sometimes
<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes	
Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs			
Have you ever smoked cigarettes or used e-cigarettes?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever drunk alcohol?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever been offered any drugs?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever used drugs (including marijuana or street drugs)?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you ever taken prescription drugs that were not given to you for a medical condition?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Acoustic Trauma			
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you often listen to loud music?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

Please print.

11 THROUGH 14 YEAR VISITS FOR PATIENTS

STAYING SAFE

Seatbelt and Helmet Use			
Do you always wear a lap and shoulder seat belt?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you always wear a life jacket when you do water sports?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Sun Protection			
Do you use sunscreen?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you visit tanning parlors?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Substance Use and Riding in a Vehicle			
Have you ever ridden in a car with someone who has been drinking or using drugs?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have someone you can call for a ride if you feel unsafe riding with someone?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Gun Safety			
Have you ever carried a gun or knife (even for self-protection)?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If there is a gun in your home, do you know how to get hold of it?	<input type="radio"/> NA	<input type="radio"/> No	<input type="radio"/> Sometimes <input type="radio"/> Yes

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Patient Information Form

	Today's Date _____
Child's Name _____	Birthdate _____ Sex <u> </u> M / F
Address _____ Zip Code _____ Social Security # _____	
Name & birthdates of child's brothers and/or sisters (include last name if different) _____ _____	
Has your child ever been seen at our practice? <input type="checkbox"/> NO <input type="checkbox"/> YES When? _____	
Have any of your child's brothers and/or sisters ever been seen at our practice? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, which brothers or sisters? _____	
If your child (or children) has not been seen before, who may we thank for referring you to our office? _____	
Name of child's previous doctor _____	
Name of parents' family doctor _____	
Name of mother's obstetrician/gynecologist _____	
How did you hear about SPC? <input type="checkbox"/> Physician / Hospital <input type="checkbox"/> Marketing Ads <input type="checkbox"/> Social Media (Facebook / Instagram) <input type="checkbox"/> Google <input type="checkbox"/> SPC's Website <input type="checkbox"/> Patient <input type="checkbox"/> Signage (building) <input type="checkbox"/> Related Profession (Physical Therapy etc.): _____ <input type="checkbox"/> Other: _____	

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____	Birthdate _____
Social Security # _____	Marital Status _____ Email _____
Address _____ Home Phone _____	
Employer _____	Occupation _____ Work Phone _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____	Birthdate _____
Social Security # _____	Marital Status _____ Email _____
Address _____ Home Phone _____	
Employer _____	Occupation _____ Work Phone _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD		
Primary Policy Holder Name	Primary Insurance	Secondary Ins./Medicaid

EMERGENCY CONTACT OTHER THAN PARENT Name _____
Relationship _____ Address _____ Home Phone _____

I authorize Dr. Blache to release any medical information necessary to process an insurance claim for my son/daughter _____ and request the insurance company to make payment to Dr. Blache . I also authorize Southern Pediatric Clinic, LLC staff and/or Dr. Blache to use the contact information listed above.		
Parent/Guardian Printed Name	Signature	Date



Financial Consent

1. **ASSIGNMENT OF BENEFITS/BILLING AUTHORIZATION CONSENT:**

- Private Insurance: The cost of our services will be billed to your insurance company. If your private insurance denies coverage, or does not pay within 90 days of billing, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).
- Private Pay: You are financially responsible of all fees due at time of service. The amount of fees for services may vary depending on changes in the patient's medical condition, progress, and physician order(s).
- State Insurance: The cost of our services will be billed to your insurance company. If your state insurance denies coverage, or retro disenrolls the patient, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).
- For those families where parents are separated or divorced, the parent who brings the child or children to the office visit and authorizes treatment is responsible for payment(s). Payments are due when services are rendered. If the divorced/custodial decree makes the non-custodial parent/guardian responsible for partial or all medical costs, it will be the responsibility of the authorizing parent to collect payment from the other parent.

2. **NOTICE OF PATIENT RESPONSIBILITY FOR CO-PAYS, PERCENTAGES & DEDUCTIBLES:**

Southern Pediatric Clinic will attempt to verify your insurance benefits and eligibility. The information we receive is based on the information you and your insurance company provide to us. As a courtesy, we will bill your insurance company for their portion of your bill. Ultimately it is your responsibility to see that we are paid appropriately by your insurance company. If the information given to us by you or your insurance company proves to be inaccurate and a balance remains, you will be billed for that balance and are responsible for payment within thirty (30) days unless you set up a payment plan with our billing specialists.

BY SIGNING BELOW, YOU INDICATE THAT:

1. You agree with the provisions of the payment source as described above. You understand that if you accept the services we have provided, you are ultimately responsible for payment. Should it be necessary to use collection services, any additional fees will also be your responsibility.
2. You authorize payment of any insurance benefits directly to Southern Pediatric Clinic.
3. You authorize the release of medical information to and from Southern Pediatric Clinic.
4. You agree to pay all co-pays, percentages, and deductibles at the time of service.

Patient Name	Date of Birth
Responsible Party Name and Signature	Today's Date

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF INSURANCE CARD(S)

Primary Policy Holder Name		Primary Insurance	Primary Insurance Policy Number
M	F	Primary Policy Sex / Date of Birth	Secondary Ins./Medicaid Policy Number
Primary Policy Sex / Date of Birth		Secondary Ins./Medicaid	Secondary Ins./Medicaid Policy Number

Office Staff Initials



**Consent & Disclosure of PHI & Treatment of Patient &
 Statement of Persons Allowed to Accompany Patient to Office Visits**

Patient Consent for Use and Disclosure of Protected Health Information (PHI) and for Treatment

Patient's Name: _____ Date of Birth: _____

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Southern Pediatric Clinic, LLC and employees., may use and disclose PHI about the said patient above to carry out treatment, payment and healthcare operations (TPO). Please review the Notice of Privacy Practices for full information regarding this statement.

1. I have reviewed the Notice of Privacy Practices for Southern Pediatric Clinic and I acknowledge that Southern Pediatric Clinic has the right to revise its Notice of Privacy Practices at any time and that I will have access to revisions.
2. I have read and understand the Notices of Privacy Practices that are in place and that I may contact the Privacy Officer listed for further questions.
3. Southern Pediatric Clinic, and all those associated, may call my home or other designated location and leave a message on voice mail or in person in reference that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
4. Southern Pediatric Clinic may treat my child and order diagnostic tests and labs for diagnosis and treatment.
5. Southern Pediatric Clinic may disclose Individually Identifiable Health Information (IIHI) that will be used to carry out TPO as referred to above, to anyone specified below who brings my child(ren) to the office for treatment.
6. Southern Pediatric Clinic will not act as mediator in separation, divorced, and/or custody battles. We must abide by the laws set forth in court-ordered documents for your child. Please make sure we have a copy on file.

DUE TO HIPAA REQUIREMENTS, PATIENTS CAN ONLY BE ACCOMPANIED TO OFFICE VISITS BY PARENTS, LEGAL GUARDIANS OR PERSONS WHOSE NAMES ARE DOCUMENTED IN THE PATIENT'S CHART. PLEASE INDICATE BELOW FOR BOTH IIHI AND HIPPA COMPLIANCE.

Name	Relationship to Patient	Disclose PHI		Accompany to Appointment	
		<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no

I have the right to request that Southern Pediatric Clinic restricts how it uses or discloses my PHI to carry out TPO. However, the practices are not required to agree to my requested restrictions, but if it doesn't, it is bound by this agreement. By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that which the practice has already made disclosures upon my prior consent. If I do not sign this consent, providers for Southern Pediatric Clinic may decline to provide treatment for my child(ren).

 Signature of Parent/Guardian

 Date

 Printed Name of Parent/Guardian



Child's Name _____

DOB _____

CELL PHONE USE POLICY

The purpose of this policy is to outline the acceptable use of cellular phone (“cellphones”) and other communication devices, including but not limited to, mobiles phones, iPhones, iPads, iPods, tablets, or any other wireless device (collectively referred to as “communication devices”) at *Southern Pediatric Clinic, LLC*. These rules are in place to protect the workers and *Southern Pediatric Clinic, LLC*, along with the privacy of each of our patients. Inappropriate use of communication devices may harm others within the office by violating HIPAA laws and regulations.

1. **Who this Policy Applies To:**

This Policy applies to patients that are being seen within the office and their family members.

2. **What devices this Policy Applies To: (Video recording or pictures during vaccinations is PROHIBITED)**

- a. All devices that can be used for recording.
- b. All devices that can be used for communicating with others.
- c. All devices that may hinder the quality of care the patient may receive.

3. **Permitted Use:**

The devices mentioned can be used in the lobby if needed. However, it is recommended that the patient or family members be conscious of others that may be in the lobby.

4. **Violations of This Policy:**

Patients or family members that violate this policy may be asked to leave and are subject to dismissal depending on circumstances.

I have read and will abide by the terms of this policy regarding the use of communication devices in this office.

Signature of Parent/Guardian or Patient _____

Date _____



PATIENT

Last Name	First Name	MI	Date of Birth
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PARENT/GUARDIAN

Last Name	First Name	MI
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Patient Eligibility Screening Record

Vaccines for Children Program

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider’s office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record may be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits as long as the child’s eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of \$21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child...		
(A) is enrolled in Medicaid (PeachState, WellCare, AmeriGroup, CareSource or SSI Medicaid).	<input type="radio"/>	OR
(B) is American Indian or Alaskan Native.	<input type="radio"/>	OR
(C) does not have health insurance.	<input type="radio"/>	OR
(D) has health insurance that does not pay for vaccines.	<input type="radio"/>	OR
(E) is enrolled in PeachCare (PeachCare will be listed as Managed Care Provider).	<input type="radio"/>	OR
(F) has health insurance that pays for vaccines.	<input type="radio"/>	

Parent/Guardian Name (print)

Signature

Date



Date _____

Child's Name _____

Date of Birth _____

PHQ-2

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling down, depressed, or hopeless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

STOP HERE if you ANSWERED “not at all” to the above 2 questions!

PHQ-9

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
3. Trouble falling or staying asleep, or sleeping too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Poor appetite or overeating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult



Patient Name: _____ **Today's Date:** _____

Please answer the following questions by checking a box to the right of the question.

PRE-PARTICIPATION SCREENING

YES NO UNSURE

Have you ever passed out or nearly passed out during or after exercise?			
Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?			
Does your heart ever race or skip beats during exercise?			
Have you ever had unusual or extreme shortness of breath during exercise?			
Do you get more tired, lightheaded or feel more short of breath more quickly than your friends during exercise?			
Have you ever had an unexplained seizure?			
Has a doctor ever told you that you have any heart problems (high blood pressure, high cholesterol, a heart murmur, a heart infection, Kawasaki disease, or other)?			
Has a doctor ever ordered a test for your heart (ECG/EKG or echocardiogram)?			

BULLYING

YES NO

Do you ever feel afraid to go to school?		
Have you ever been bullied at school, in your neighborhood, or online?		
Have you seen other kids being bullied?		
Do you know who you can go to for help?		

■ 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? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>	
MEDICAL QUESTIONS		Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>	
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>	
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	
23. Do you or does someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>	
24. Have you ever had or do you have any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICAL QUESTIONS (CONTINUED)		Yes	No
25. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	
27. Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>	
28. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
FEMALES ONLY		Yes	No
29. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>	
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: _____

■ 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?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - 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: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 	<input type="checkbox"/>	
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 	<input type="checkbox"/>	

^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

■ 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: _____

HPV (Human Papillomavirus) Vaccine: *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

HPV (Human papillomavirus) vaccine can prevent infection with some types of human papillomavirus.

HPV infections can cause certain types of cancers including:

- cervical, vaginal and vulvar cancers in women,
- penile cancer in men, and
- anal cancers in both men and women.

HPV vaccine prevents infection from the HPV types that cause over 90% of these cancers.

HPV is spread through intimate skin-to-skin or sexual contact. HPV infections are so common that nearly all men and women will get at least one type of HPV at some time in their lives.

Most HPV infections go away by themselves within 2 years. But sometimes HPV infections will last longer and can cause cancers later in life.

2 HPV vaccine

HPV vaccine is routinely recommended for adolescents at 11 or 12 years of age to ensure they are protected before they are exposed to the virus. HPV vaccine may be given beginning at age 9 years, and as late as age 45 years.

Most people older than 26 years will not benefit from HPV vaccination. Talk with your health care provider if you want more information.

Most children who get the first dose before 15 years of age need 2 doses of HPV vaccine. Anyone who gets the first dose on or after 15 years of age, and younger people with certain immunocompromising conditions, need 3 doses. Your health care provider can give you more information.

HPV vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of HPV vaccine**, or has any **severe, life-threatening allergies**.
- Is **pregnant**.

In some cases, your health care provider may decide to postpone HPV vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting HPV vaccine.

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- Soreness, redness, or swelling where the shot is given can happen after HPV vaccine.
- Fever or headache can happen after HPV vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.



5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call **1-800-232-4636 (1-800-CDC-INFO)** or
 - Visit CDC's website at www.cdc.gov/vaccines



Meningococcal ACWY Vaccine:

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Meningococcal ACWY vaccine can help protect against **meningococcal disease** caused by serogroups A, C, W, and Y. A different meningococcal vaccine is available that can help protect against serogroup B.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

Anyone can get meningococcal disease but certain people are at increased risk, including:

- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of *N. meningitidis*, the bacteria that cause meningococcal disease
- People at risk because of an outbreak in their community

2 Meningococcal ACWY vaccine

Adolescents need 2 doses of a meningococcal ACWY vaccine:

- First dose: 11 or 12 year of age
- Second (booster) dose: 16 years of age

In addition to routine vaccination for adolescents, meningococcal ACWY vaccine is also recommended for **certain groups of people**:

- People at risk because of a serogroup A, C, W, or Y meningococcal disease outbreak
- People with HIV
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called “persistent complement component deficiency”
- Anyone taking a type of drug called a complement inhibitor, such as eculizumab (also called Soliris®) or ravulizumab (also called Ultomiris®)
- Microbiologists who routinely work with isolates of *N. meningitidis*
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa
- College freshmen living in residence halls
- U.S. military recruits

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of meningococcal ACWY vaccine**, or has any **severe, life-threatening allergies**.

In some cases, your health care provider may decide to postpone meningococcal ACWY vaccination to a future visit.

Not much is known about the risks of this vaccine for a pregnant woman or breastfeeding mother. However, pregnancy or breastfeeding are not reasons to avoid meningococcal ACWY vaccination. A pregnant or breastfeeding woman should be vaccinated if otherwise indicated.



People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting meningococcal ACWY vaccine.

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- Redness or soreness where the shot is given can happen after meningococcal ACWY vaccine.
- A small percentage of people who receive meningococcal ACWY vaccine experience muscle or joint pains.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call **1-800-232-4636 (1-800-CDC-INFO)** or
 - Visit CDC's www.cdc.gov/vaccines

Vaccine Information Statement (Interim)
**Meningococcal ACWY
Vaccines**



Office use only

8/15/2019 | 42 U.S.C. § 300aa-26

Tdap (Tetanus, Diphtheria, Pertussis) Vaccine: *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Tdap vaccine can prevent **tetanus, diphtheria, and pertussis**.

Diphtheria and pertussis spread from person to person. Tetanus enters the body through cuts or wounds.

- **TETANUS (T)** causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.
- **DIPHTHERIA (D)** can lead to difficulty breathing, heart failure, paralysis, or death.
- **PERTUSSIS (aP)**, also known as “whooping cough,” can cause uncontrollable, violent coughing which makes it hard to breathe, eat, or drink. Pertussis can be extremely serious in babies and young children, causing pneumonia, convulsions, brain damage, or death. In teens and adults, it can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

2 Tdap vaccine

Tdap is only for children 7 years and older, adolescents, and adults.

Adolescents should receive a single dose of Tdap, preferably at age 11 or 12 years.

Pregnant women should get a dose of Tdap during every pregnancy, to protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

Adults who have never received Tdap should get a dose of Tdap.

Also, **adults should receive a booster dose every 10 years**, or earlier in the case of a severe and dirty wound or burn. Booster doses can be either Tdap or Td (a different vaccine that protects against tetanus and diphtheria but not pertussis).

Tdap may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria, or pertussis**, or has any **severe, life-threatening allergies**.
- Has had a **coma, decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine (DTP, DTaP, or Tdap)**.
- Has **seizures or another nervous system problem**.
- Has ever had **Guillain-Barré Syndrome** (also called GBS).
- Has had **severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diphtheria**.

In some cases, your health care provider may decide to postpone Tdap vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting Tdap vaccine.

Your health care provider can give you more information.



4 Risks of a vaccine reaction

- Pain, redness, or swelling where the shot was given, mild fever, headache, feeling tired, and nausea, vomiting, diarrhea, or stomachache sometimes happen after Tdap vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

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Vaccine Information Statement (Interim)
Tdap (Tetanus, Diphtheria,
Pertussis) Vaccine



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