Instruction Sheet for Physicals at Kimbrough Ambulatory Care Center

1. Please complete all appropriate forms **BEFORE** coming for the Sports Physicals.

    a. **CYS Sports Physical Form**. Complete Part I, sign and date.

    b. **Pediatric Routine Physical**. Used for children ages 2 - 12. Complete Part I and II.

    c. **Health Examination Record**. Used for children ages 13 and older. Complete Part I and II.

    d. **Third Party Collection Form**. Fill out items 1 – 10 and 13. Item 17, sign and date. Do not complete if there is a form already in the medical records for this calendar year, 2006.

2. Bring the following items **with you** when you come for the Sports Physical:

    a. All **COMPLETED** forms

    b. Each child's **ID CARD**, if 10 years of age or older.

    c. Each child's **MEDICAL RECORDS**, if not maintained at Kimbrough.

    d. Each child's **YELLOW SHOT RECORD**.

    e. Third **PARTY INSURANCE CARD**, if applicable.

    f. **PROOF OF GUARDIANSHIP**, if you are not the parent of the child being seen.

3. Complying with the above will ensure a smoother flow and decrease your wait time.

Child & Youth Sports Physical/Medical Evaluation
Fort George G. Meade, MD

Part I-Medical Evaluation of Youth for Participation in Child & Youth Services

To be completed by Parent or Guardian and submitted to the examining physician before he examines the youth.

Name of Participant _____ Date of Birth _____/_____/_____
Parent or Guardian _____

Personal Health of Participant (Check correct reply)	Yes	No
1. Has had injuries or accidents requiring medical attention	___	___
2. Has had a surgical operation	___	___
3. Has been in a hospital	___	___
4. Has had a sickness lasting longer than one week	___	___
5. Takes medicine now or regularly	___	___
6. Has a condition now under treatment by a physician	___	___
7. Is there any reason this youth should not take part in any sports	___	___
8. Has had complete poliomyelitis immunization by injection or vaccine	___	___

	Yes	No
9. Has had tetanus toxic and booster inoculation Date of last booster _____/_____/_____	___	___
10. Has seen a dentist within the past six months	___	___
11. To my knowledge the paired organs that follow are present and healthy:		
Eyes	___	___
Ears (Hearing)	___	___
Lungs	___	___
Kidneys	___	___
Testicles or ovaries	___	___
Arms/Legs	___	___
Fingers/Toes	___	___

If you answered "Yes" to questions one through seven explain here with names and dates:_____
_____
_____

If you answered "No" to questions eight through eleven here with names and dates:_____
_____
_____

I give my permission for the physician to complete Part II for confidential use in meeting my child's health requirements for Child & Youth Services _____ _____/_____/_____
Signature of Parent or Guardian Date

Part II-Medical Evaluation of Youth for Participation in Child & Youth Services
(To be completed by a Medical Provider)

Name of Participant _____ Grade_____
Significant past illnesses or injuiries _____

Provider's Examination (Circle and explain any abnormal findings)

Height_____ Weight_____ Blood Pressure_____ Pulse Rate_____
Eyes_____ Visual_____R/L_____ Ears_____ Hearing _____R/L_____
Teeth (cavaties, dentures, braces) _____ Respiratory_____ Breasts (M&F) _____
Cardiovascular (pulses) _____ Abdomen (hernia, spleen, liver) _____Genitalia & Anus_____
Neuromuscular_____ Spine (cervical, thoracic, lumbar) _____
Extremities (special attention to knees/ankles) _____
Additional explanations of abnormal
findings:_____
_____
_____

Laboratory:
Urinalysis: Protein_____
Sugar_____
Other_____
*Tuberculin Test_____
*Chest X-ray_____
*Other Laboratory Test_____ *If ordered by physician_____

I have on this date personally examined this participant, review the history and other data recorded on both sides of this form and find that this participant physically able to compete in supervised activities listed below which are **"CIRCLED"**

Baseball	Flag Football	Cheerleading	Martial Arts	Bowling
Basketball	Football	Soccer	Tennis	Other: _____
Dance	Gymnastics	Swimming	Track & Field	

_____ _____

Provider's Signature Provider's Address

_____ _____

Provider's Name Printed/Typed Provider's Telephone

_____/_____/_____

Date of Examination

THIRD PARTY COLLECTION PROGRAM - RECORD OF OTHER HEALTH INSURANCE

(Read Privacy Act Statement before completing this form.)

Form Approved
OMB No. 0704-0323
Expires Dec 31, 2006

 PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO REQUESTING MILITARY TREATMENT FACILITY.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sec. 1095; EO 9397.
PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to the Military Treatment Facility (MTF) patient. Such monetary benefits accruing to the MTF will be used to enhance health care delivery in the MTF.
ROUTINE USE(S): The information on this form will be released to your insurance company.
DISCLOSURE: Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services.

1. PATIENT NAME *(Last, First, Middle Initial)*	2. SSN	3. DATE OF BIRTH *(YYYYMMDD)*	4. MARITAL STATUS *(X)* ☐ SINGLE ☐ MARRIED ☐ DIVORCED/WIDOWED

5a. STREET ADDRESS *(Include apartment number)*	b. CITY	c. STATE	d. ZIP CODE	6. HOME TELEPHONE NO. ( )

7. SPONSOR'S BRANCH OF SERVICE	8. SPONSOR FAMILY MEMBER PREFIX/ SSN	9a. SPOUSE NAME *(Last, First, Middle Initial)*

10a. PATIENT'S EMPLOYER NAME	b. TELEPHONE NUMBER ( )	b. SPOUSE'S EMPLOYER *(Name, Address and Telephone No.)*
c. EMPLOYER ADDRESS *(Include ZIP Code)*		

11. IS PATIENT'S CONDITION/APPOINTMENT RELATED TO AN ACCIDENT *(X one)* ☐ YES ☐ NO	a. DATE OF INJURY/ACCIDENT *(YYYYMMDD)*	b. CITY AND STATE WHERE ACCIDENT OCCURRED

c. TYPE OF ACCIDENT *(X)* ☐ AUTO ☐ BOAT ☐ HOME ☐ AIRPLANE ☐ WORKERS' COMPENSATION ☐ SLIP & FALL ☐ OTHER _____

d. BRIEFLY DESCRIBE HOW INJURY/ACCIDENT OCCURRED

e. INSURANCE COMPANY NAME	f. POLICY NUMBER	g. COMPANY ADDRESS *(Include ZIP Code)*

h. TELEPHONE NUMBER ( )	i. NAME OF POLICY HOLDER/INSURED	j. CLAIM NUMBER

12. DO YOU HAVE MEDICARE/MEDICAID *(X one)* ☐ YES ☐ NO			
a. MEDICARE PART A NUMBER	b. MEDICARE PART B NUMBER	c. MEDICAID NUMBER	d. ISSUING STATE

13. ARE YOU COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY? *(Other than Medicare, Medicaid, TRICARE or TRICARE/CHAMPUS Supplement)*	☐ YES	☐ NO

14.a. PRIMARY MEDICAL INSURANCE COMPANY NAME	15.a. SECONDARY MEDICAL INSURANCE COMPANY NAME
b. ADDRESS *(Include ZIP code)*	b. ADDRESS *(Include ZIP code)*
c. TELEPHONE NUMBER ( ) / d. IDENTIFICATION NUMBER/GROUP NUMBER	c. TELEPHONE NUMBER ( ) / d. IDENTIFICATION NUMBER/GROUP NUMBER
e. POLICY HOLDER'S NAME *(Last, First, Middle Initial)*	e. POLICY HOLDER'S NAME *(Last, First, Middle Initial)*
f. SSN / g. DATE OF BIRTH *(YYYYMMDD)*	f. SSN / g. DATE OF BIRTH *(YYYYMMDD)*
h. POLICY HOLDER'S EMPLOYER NAME, ADDRESS AND TELEPHONE NO.	h. POLICY HOLDER'S EMPLOYER NAME, ADDRESS AND TELEPHONE NO.
i. EFFECTIVE DATE OF POLICY *(YYYYMMDD)*	i. EFFECTIVE DATE OF POLICY *(YYYYMMDD)*

16. FAMILY MEMBERS COVERED BY ABOVE POLICIES *(Use additional pages if necessary)*

a. NAME *(Last, First, Middle Initial)*	b. SSN	c. DATE OF BIRTH *(YYYYMMDD)*	a. NAME *(Last, First, Middle Initial)*	b. SSN	c. DATE OF BIRTH *(YYYYMMDD)*

17. CERTIFICATION. I certify that the above information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by 18 USC 1001, which provides for a maximum fine of $10,000 or imprisonment for five years, or both. For non-DoD beneficiaries, the below signature authorizes and requests that the proceeds of any and all benefits be paid directly to the Military Treatment Facility (MTF) for health care services provided me and/or my minor dependents. This signature authorizes Medical Service Account (MSA) patients' release of medical information (medical records) for claims.

a. SIGNATURE	b. DATE *(YYYYMMDD)*