315 N Washington Street
Viborg, SD 57070-0368
Ph: (605) 326-5161
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pioneermemorial.org

PIONEER MEMORIAL
HOSPITAL & HEALTH SERVICES

Attention: Irene-Wakonda Student Athletes and Parents

Pioneer Memorial Clinics will be offering athletic physicals. Two options are available:

Option 1 – To be done at the SCHOOL

- When and Where: **Wednesday, July 26th from 8:00am-10:30am, Irene School**
- Please bring the athletic physical forms with your part completed. **Physicals will not be done without all appropriate parent/guardian signatures**. Forms are available through your school.
- **$30** is due when you arrive on this date.

Option 2 – To be done at the CLINIC

- Please make an appointment with the clinic:

Centerville Medical Clinic	**563-2411**
Parker Medical Clinic	**297-3888**
Viborg Medical Clinic	**326-5201**

- **What to schedule? Sports physical or well-child visit?**
  - An annual well-child visit includes a comprehensive look at the overall health & well-being, with both physical and mental health concerns addressed. Sports physicals focus particularly on physical growth, cardiovascular health, musculoskeletal health, and risk reduction.
  - ***A well-child visit can double as a sports physical, but a sports physical can't be considered a well-child visit.***
- Please bring the athletic physical forms with your part completed. **Physicals will not be done without all appropriate parent/guardian signatures**. Forms are available through your school.
- $30 is due at the time of service if scheduled as a sports physical. If a well-child visit is scheduled, the well-child visit will be filed with your insurance company at the standard price. Most insurance companies fully cover well-child visits once a year; this can be confirmed by calling the phone number on your insurance card.

Please feel free to contact the clinics listed above with questions.

Patient name _____ _____
Legal name Last First Middle initial Soc. Sec. #

Alternative names/maiden/nicknames _____ Hispanic/Latino Ethnical Background ☐ Yes ☐ No

Sex ☐ Male ☐ Female Birth date _____ Race _____

Marital status ☐ M ☐ S ☐ Divorce ☐ Widowed ☐ Separated Email _____

Military status ☐ Active Duty ☐ Retired ☐ Veteran ☐ Never Served

Address _____
Street PO Box City State Zip

Home phone ( )	Work phone ( )	Cell phone ( )
Employer	Occupation	

Employer address _____
Street PO Box City State Zip

Spouse's name	Birth date	Soc. Sec. #
Employer	Occupation	
Work phone ( )	Cell phone ( )	

Employer address _____
Street PO Box City State Zip

RESPONSIBLE PARTY / BILLING INFORMATION (If patient is a minor)

Mother's name	Birth date	Soc. Sec. #
Address _____ Street PO Box City State Zip		Home phone ( )
		Work phone ( )
Employer	Occupation	Cell phone ( )

Employer address _____
Street PO Box City State Zip

Father's name	Birth date	Soc. Sec. #
Address _____ Street PO Box City State Zip		Home phone ( )
		Work phone ( )
Employer	Occupation	Cell phone ( )

Employer address _____
Street PO Box City State Zip

EMERGENCY CONTACT

Name	Relationship to patient

Address _____
Street PO Box City State Zip

Home phone ( )	Work phone ( )	Cell phone ( )

FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for all charges related to services provided by Pioneer Memorial Hospital & Health Services (PMHHS). I also agree to abide by PMHHS' payment guidelines, including payment of any periodic late fees. If I have questions about my financial responsibility for PMHHS' charges, or would like to see a copy of the Collection Policy; I may contact PMHHS' Patient Financial Services

Further, if I am provided health care services by a health care provider other than PMHHS, while a patient within a PMMHS facility or entity, I am financially responsible for all charges related to services provided by those health care providers. PMHHS' billing statements will not include charges by health care providers who are independent of PMHHS.

As a patient, I have given or will give PMHHS or one its affiliates my home phone number, mobile phone number, email address, and/or other contact information. By signing below, I agree to be contacted by PMHHS, its affiliates, and/or a company hired by them using automatic dialing systems, recorded or artificial voice messages, text messages, emails, and/or similar methods. The purpose for these messages may include appointment reminders or other health care messages, patient feedback, surveys, marketing or promotional messages, upcoming events, unpaid balance messages, and/or other business messages.

ASSIGNMENT OF PAYER BENEFITS

I agree PMHHS and my attending health care provider will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan or insurance policy that I have or another third party that will pay the charges I have incurred. All Payers may make payments directly to PMHHS and my attending health care provider. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to PMHHS and my attending health care provider. I agree that unless PMHHS or my attending health care provider have agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services.

MEDICARE BENEFICIARY REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to PMHHS and my attending health care provider for any services furnished me by PMHHS and my attending health care provider, including physician services. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits for related services.

ACKNOWLEDGMENT

I have read the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified in the below label on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient. A copy of this form is as effective and valid as the original.

_____ _____ _____ a.m./p.m.

Signature of Patient or Authorized Person | Date | Time

_____

Relationship to Patient (if not patient signing)

PIONEER MEMORIAL
HOSPITAL & HEALTH SERVICES

315 N. Washington•Viborg, SD
57070
605-326-5161 Fax: 605-326-5734

STATEMENT OF FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

BUS 1064
Revised 12/4/19

Patient Name _____

DOB _____

SDHSAA CONSENT FOR PARTICIPATION IN ACTIVITIES

Student Name: _____ **Date of Birth:** _____

School Year: 2023-24 School Year **Place of Birth:** _____

Name of High School: _____

The parent and student, by signing this form, hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.

2. Understand and agree that:
   (a) By this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation;
   (b) Participation in any athletic activity may involve injury of some type;
   (c) The severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death;
   (d) Even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility; and;
   (e) By signing this form, I/we give our consent for the listed student to compete in SDHSAA approved athletics for the school year as listed on this form. Further, I/we give our permission for our child to participate in organized high school athletics, realizing that such activity involves the potential for injury and harm which exists as an inherent element in all sports.

3. Understand, consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and

4. Understand, consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. If I/we do not wish to have any or all such information disclosed, I/we must notify the above-mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.

_____ _____

Signature of Parent **Date**

_____ _____

Signature of Student **Date**

SDHSAA CONSENT FOR MEDICAL TREATMENT FORM

Student Name: _____ **Date of Birth:** _____

The SDHSAA recommends that all member schools receive consent from all students and parent/guardians prior to activities, to ensure that medical care can be provided to the student during any activity away from home. This form should be kept both on-file at the school, as well as in the possession of a student's coach/sponsor authorizing as below:

CONSENT FOR MEDICAL TREATMENT (for those children 18 and under at any time during the 2023-24 school year):

I, _____, am the (circle one) Parent or Legal Guardian, of _____, who participates in activities and/or athletics for _____ High School. I hereby consent to necessary medical services that may be required while said child is under the supervision of an employee of the fore-mentioned high school while on a school-sponsored activity, and hereby appoint said employee to act on behalf of myself in securing medical services from any duly licensed medical provider. Signatures on this form do not constitute consent for vaccinations of any kind.

_____ _____

Signature of Parent **Date**

CONSENT OF PARTICIPANT (for all students to complete):

I, _____, have read the above consent for medical treatment form signed above, or, as an individual of majority age, consent to those same medical services and actions as indicated above on this form.

_____ _____

Signature of Student **Date**

SDHSAA CONSENT FOR MEDICAL RELEASE FORM (HIPAA)

Student Name: _____ **Grade:** _____ **Date of Birth:** _____

I/We the undersigned do hereby:

1. Authorize the use or disclosure of the above named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information for the purposes of evaluating, observing, diagnosing and creating treatment plans for injuries that occur during the time period covered by this form, or, from pre-existing conditions that require care plans pertaining to participation during the time period covered by this form.

2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the medical care of this student.

3. This information for which I/we are authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. This authorization will expire on July 1, 2024.

6. I understand that once the above information is disclosed, there is potential for it to be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. Schools, School districts and school personnel are to uphold the bounds of FERPA. As such, disclosure and re-disclosure by schools or school employees must be done in compliance with FERPA guidelines.

7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Parent **Date**

_____ _____

Signature of Student (if over 18 or turning 18 before July 1, 2024) **Date**

This form must be completed annually and must be available for inspection at the school

SDHSAA CONCUSSION FACT SHEET FOR STUDENTS-

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

What are the symptoms of a concussion?

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should I do if I think I have a concussion?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

How can I prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
- Follow you coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

IT IS BETTER TO MISS ONE GAME THAN A WHOLE SEASON – SEE SOMETHING – SAY SOMETHING!!!

Student's Name (Please Print)	**Date**
Signature of Student	**Date**
Parent's Signature	**Date**

SDHSAA CONCUSSION FACT SHEET FOR PARENTS-

What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

What are the signs and symptoms?

You can't see a concussion, Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed By Parents or Guardians	Symptoms Reported by Athlete
• Appears dazed or stunned • Is confused about assignment or position • Forgets an instruction • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Loses consciousness (even briefly) • Shows mood, behavior, or personality changes • Can't recall events prior to hit or fall • Can't recall events after hit or fall	• Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light or noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just not "feeling right" or is "feeling down"

How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

What should you do if you think your child has a concussion?

1. **Keep your child out of play.** If your child has a concussion, her/his brain needs time to heal. Don't let your child return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your child is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your child to return to sports.
3. **Teach your child that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your child convince you that s/he's "just fine".
4. **Tell all of your child's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your child has ever had a concussion. Your child may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your child's coaches, school nurse, and teachers. If needed, they can help adjust your child's school activities during her/his recovery.

_____ _____

Parent's Name **Date**

_____ _____

Signature of Parent **Date**

_____

Student's Name

SDHSAA HEALTH HISTORY FORM - To be completed (with parent/guardian if student is under 18) in years when a physical exam is given, prior to the exam.

Name: _____ **Date of Birth:** _____

Date of Exam: _____ **Sports:** _____

List all past and current medical conditions:	
Have you ever had surgery? If Yes, list all procedures:	
List all prescriptions, over-the-counter meds or supplements you currently take:	
Do you have any allergies? If Yes, Please list them here:	

Over the last two weeks, how often have you been bothered by the following problems? (Circle Response)

	Not At All	Several Days	Over Half the Days	Nearly Every Day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest in pleasure or doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
A sum of 3 or greater is considered positive on either subscale (Q1+2, or Q3+4) for screening purposes				

ANSWER EACH OF THE FOLLOWING QUESTIONS SPECIFIC TO "IN THE PAST YEAR"
& EXPLAIN ANY YES ANSWERS ON THE BACK OF THIS SHEET:

GENERAL QUESTIONS	Yes	No
1. Do you have any concerns you'd like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illnesses?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? (Example: electrocardiography or echocardiography)		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before 35 years of age (including drowning or unexplained car crash)		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS) short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CVPT)?		
13. Has anyone in your family had a pacemaker or implanted defibrillator before age 35?		
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 a game?		

BONE AND JOINT QUESTIONS, CONTINUED:	Yes	No
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have recurring skin rashes or rashes that come and go, including herpes or MRSA?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?		
21. Have you ever had numbness, tingling or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had, or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to, or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet, or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
29. Have you ever had COVID-19?		
FEMALES ONLY	**Yes**	**No**
30. Have you ever had a menstrual period?		
31. How old were you when you had your first period?		
32. When was your most recent period?		
33. How many periods have you had in the past 12 months?		

CERTIFICATION OF HEALTH: I hereby state that, to the best of my knowledge, my answers on this form are complete and correct:

Signature of Athlete: _____

Signature of parent/guardian (if under 18): _____

Date: _____

SDHSAA PREPARTICIPATION PHYSICAL EXAM FORM

Athlete Name: _____ **Date of Birth:** _____

Date of Exam: _____ **Annual/Biennial/Triennial:** _____

Physician Reminders:

1. **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, vaping, chewing tobacco, snuff or dip?
   - Over the past 30 days, have you used 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 seatbelt or helmet?
2. **Consider reviewing questions on cardiovascular symptoms (#4-13 on health history form)**

EXAMINATION		
Height:	Weight:	BP:
Pulse:	Vision: R 20/ L 20/	Corrected?:

MEDICAL	**Normal**	**Abnormal Findings**
Appearance		
Head/Mouth		
Eyes, ears, nose and throat - Pupils equal & Hearing		
Lymph Nodes		
Heart* -Heart sounds, murmurs, pulse, rhythm, auscultation		
Lungs		
Abdomen - Liver/Spleen, masses		
Skin - HSV, Lesions, Staph, MRSA, etc.		
Neurological		
MUSCULOSKELETAL	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, Hand and Fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional • Double-leg squat test, single-leg squat test, box drop or step drop test		

* *Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or exam findings, or a combination*

Sports Participation Recommended for (Mark One):

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendation for further evaluation or treatment of: _____

☐ Medically eligible for certain sports (list here): _____

☐ Not medically eligible pending further evaluation: _____

☐ Not medically eligible for any sports: _____

Name of Examiner: _____

Signature of Examiner: _____

Date of Exam: _____

Note: SDCL allows Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Licensed Physician Assistant and Licensed Nurse Practitioners as those that can provide this recommendation.