2024-2025

Warrior Wellness Center
Sports Physical Consent Form

WARRIOR WELLNESS CENTER AT CHS

MarillacHealth

The Warrior Wellness Center (WWC) is an integrated health center inside of Central High School that provides in-school access to medical, behavioral health, and dental care. Full scope care is available to students and staff of Central High School only. However, sports physicals completed at the WWC are open to all students of District 51. This consent form is for sports physicals only and does not enroll the student in additional services at WWC.

Students are allowed to attend appointments by themselves once a signed consent form has been received. Students will be sent home with a copy of their completed sports physical form, and it is the responsibility of the child and parent to provide this form to the school for sports participation.

Purpose of examination: The sports physical examination is conducted to evaluate the overall health and fitness of the individual in relation to their participation in sports activities. The examination will focus on identifying any existing medical conditions that may affect the individual's ability to engage in physical activities safely.

I understand that the medical professional conducting the sports physical examination may provide recommendations or restrictions based on the results of the examination or information received from the health information exchange. These recommendations may include modifications to sports participation, further medication evaluations or restrictions, or treatment plans. I have the opportunity to ask questions and discuss any concerns related to this examination either at the time of the exam or afterward via phone if I am unable to attend.

Demographic Information

Student First Name _____ Last Name _____ Date of Birth _____

Current Grade_____ Student Social Security Number _____ Student Phone Number_____

Parent/Guardian First Name _____ Last Name _____ Phone _____

Parent/Guardian First Name _____ Last Name _____ Phone _____

Physical Address _____ City _____ State _____ Zip Code _____

*Below please put the address where you receive mal. If you do not have a mailing address, please check this box: ☐

Mailing Address _____ City _____ State _____ Zip Code _____

Email Address _____ Student Email Address_____

Does your child have a Primary Care Provider (Please check one): **YES** **NO** If yes, who: _____

What school does your child attend: _____

RACE *(CIRCLE AT LEAST ONE)*		**PRIMARY LANGUAGE** *(CIRCLE AT LEAST ONE)*	**SEXUAL ORIENTATION** *(CIRCLE ONE)*	**ETHNICITY** *(CIRCLE ONE)*	**GENDER IDENTITY** *(CIRCLE ONE)*
BLACK OR AFRICAN AMERICAN		AMERICAN SIGN LANGUAGE	STRAIGHT	HISPANIC/LATINO ORIGIN	MALE
AMERICAN INDIAN OR ALASKA NATIVE		ENGLISH	BISEXUAL	NOT HISPANIC/LATINO ORIGIN	FEMALE
ASIAN		FRENCH	LESBIAN	NOT PROVIDED	GENDERQUEER/NONBINARY
WHITE		POLISH	GAY		TRANSGENDER WOMAN/ TRANSGENDER FEMALE
NATIVE HAWAIIAN	OTHER PACIFIC ISLANDER	RUSSIAN	SOMETHING ELSE		TRANSGENDER MAN/ TRANSGENDER MALE
NOT PROVIDED		SPANISH	DO NOT KNOW		OTHER
		OTHER	CHOOSE NOT TO DISCLOSE		CHOOSE NOT TO DISCLOSE

Financial Arrangements

A sports physical costs $20. This is not covered by your insurance unless it is done in coordination with a well child check. This is available through WWC only if our clinic provides your child's primary care. Unless discussed at scheduling, the fee for a sports physical is $20. We have a hardship fund that can support this cost if that is a barrier to your family. Please inquire about this at the front desk.

Privacy Practices

I hereby acknowledge that I have been offered a copy of the integrated health center's Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available on the Marillac Health web site: https://marillachealth.org/hipaapolicy/

I understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for the health services I receive at the integrated health center. CDPHE is legally able to receive information regarding services provided to patients. CDPHE receives combined data for all patients, and **this data does not identify any individual patient or patient identifying information.**

I grant consent for my child/self to undergo a sports physical examination conducted by a licensed medical professional at the Warrior Wellness Center. By signing below I indicate that I have read and understood the information presented in this consent form and agree to the terms outlined.

Signature: _____ Date: _____