



Please fill out this form and return to the school nurse.

Dear Parent,

Spartan Health Center will be offering Sports Physicals to all students of Lima City Schools on May 31st starting at 8:30a.m. - 12 p.m. for boys and 1:30p.m. -3:30p.m. for girls. If you would like your child to receive this service please complete the form below and send with your child the day of the physical. This form is required in order to complete the sports physical.

Check Yes or NO

YES _____ I want my child to receive a sports physical from Spartan Health Center

NO _____ I do NOT want my child to receive a Sports Physical

Child's Information (Please Print)

Child Name: _____ Date of Birth: _____

Social Security Number: _____ (REQUIRED)

Please Circle

Gender: Male Female

Race: White Black Asian Multi-Race Native American/Alaskan Native Other

Ethnicity: Hispanic Non-Hispanic Declined Unknown

Grade: _____ Teacher: _____ School: _____

Address: _____ City: _____ Zip code: _____

Phone #: _____

Does anyone in your household work on a farm? Yes No

Insurance Information

Does your child have Medicaid? Yes No Private Insurance? Yes No

Name of Medicaid/ Private Insurance Company _____

Policy Holder Name: _____ Employer _____

ID Number _____ Group Number _____

Health History

Does your Child have any serious health problems? Yes No

If Yes, please explain: _____

Does your Child have any medication, food or environmental allergies? Yes No

If Yes, please explain: _____

Does your Child have a Heart Problem? Yes No

If Yes, please explain: _____

Does your child take any prescribed or OTC medications? Yes No

If Yes, please explain: _____

Is there a Family History of any chronic illnesses? Yes No

If Yes, please explain: _____

Does your Child have any Chronic Illness? Yes No

If Yes, please explain: _____

Has your Child ever had surgery? Yes No

If Yes, please explain: _____

Receipt of Privacy Practices -- Acknowledgement Form

I Hereby acknowledge that I received the Notice of Privacy Practices of Health Partners of Western Ohio, which sets for the ways in which my personal health information may be used or disclosed by Health Partners of Western Ohio, and outlines my rights with respect to such information.

Signature of Parent/Guardian: _____

Date: _____