STATE WELLNESS CENTER (SWC)
School or Sports Physical Form

Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:**
Primary Insurance Contract Number:		**Primary Insurance Group Number:**	
Secondary Insurance Contract Number:		**Secondary Insurance Group Number:**	
Address:	**Pharmacy:**	**Primary Physician:**	
Specialist Physician Name And Specialty:		**Specialist Physician Name And Specialty:**	
Emergency Contact:		**Phone Number:** **Relation:**	

Please list anyone with whom you give us permission to discuss your protected health information:

_____ _____
Name **Relationship to Patient**

_____ _____
Name **Relationship to Patient**

Medical History (check all that apply):

☐ Allergic Rhinitis (Hayfever)	☐ High Blood Pressure
☐ Anemia or other blood problems	☐ Eye problems
☐ Anxiety or mental health issue	☐ Gout
☐ Asthma	☐ Headaches (Type: _____)
☐ Arthritis (Type: _____)	☐ Stroke
☐ Urinary (Type: _____)	☐ Sleep Apnea
☐ Cancer (Type: _____)	☐ Thyroid Disorder
☐ Heartburn	☐ Heart Disease
☐ Irritable Bowel or other gastrointestinal problem	☐ High Cholesterol
☐ Pneumonia or respiratory problem	☐ Diabetes / High Blood Sugar
☐ Other:	

Surgery or Hospitalization (List additional surgeries or hospitalizations on back of page):

Year	Reason for surgery or hospitalization, including emergency department visits	Year	Reason for surgery or hospitalization, including emergency department visits

Medications (Please list all prescription and over the counter medications. List additional medications on back of page):

Medication Name	Dose (milligrams, units, etc.)	When do you take it? (time of day)	When did you start taking this medication?	What is this medication for?

Allergies (List additional allergies on back of page):

Medication or other allergies	Type of reaction

Preferred Method of Communication

Home phone #: _____and/or Cell phone #: _____

Check one or more of the following:

_____ Leave a message with detailed information

_____ Leave a message with call back name and phone number only

_____ Mail correspondence to home address listed in my record

_____ Mail correspondence to the address below: _____

Signature: _____

Date: _____

AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR SERVICE. I hereby consent to the services provided by the State Wellness Center. I understand that these services may include limited physical assessment, lab testing and non-invasive testing along with cognitive services. _____ (initial)

PRIVACY POLICY. I acknowledge having received the "Notice of Privacy Practices". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Notice. I understand that I may revoke my consent for release of my health care information in writing, except to the extent the State Wellness Center has already made disclosures with my prior consent. _____ (initial)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION. I authorize use and disclosure of my protected health information for the purposes of diagnosis or treatment, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the State Wellness Center. I authorize the release of any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the State Wellness Center may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurer or its designated agent. _____ (initial)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT. I authorize payment to be made directly to the State Wellness Center for insurance benefits payable to me. I understand that I am financially responsible for any covered or non-covered services, as defined by my insurer. _____ (initial)

_____	_____	_____
Patient or Authorized Person Signature	Relationship	Date

PHARMACY HEALTH SERVICES
AUPCC-2155 Walker Building
AU Employee Pharmacy- 2150 Walker Building
AU Student Pharmacy- 400 Lem Morrison Ave
State Wellness Center and SWC Pharmacy - 101 So. Union St., Montgomery, AL 36104
Auburn, Alabama 36849

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Pharmacy Health Services is required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

Pharmacy Health Services is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Your Health Information Rights

You have the following rights with respect to PHI about you:

Obtain a paper copy of the Notice upon request. You may request a copy of the Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. To obtain a paper copy, contact the Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of PHI about you by sending a written request to Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849. We are not required to agree to those restrictions.

Inspect and obtain a copy of PHI. You have the right to access and copy PHI about you contained in a designated record set for as long as Pharmacy Health Services maintains the PHI. The designated record set usually will include prescription and billing records. To inspect or copy PHI about you, you must send a written request to Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849. We may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to PHI about you, you may request that the denial be reviewed.

Request an amendment of PHI. If you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment, you must send a written request to Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849. You must include a reason that supports your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give a rebuttal to your statement.

Receive an accounting of disclosures of PHI. You have the right to receive an accounting of the disclosures we have made of PHI about you after April 14, 2003, for most purposes other than treatment, payment, or health care operations. The accounting will exclude certain disclosures, such as disclosures made directly to you, disclosures you authorize, disclosures to friends or family members involved in your care, and disclosures for notification purposes. The right to receive an accounting is subject to certain other exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849. Your request must specify the time period, but may not be longer than six years. The first accounting you request within a 12 month period will be provided free of charge, but you may be charged for the cost of providing additional accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

Request communications of PHI by alternative means or at alternative locations. For instance, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of PHI about you, you must submit a request in writing to Auburn University Pharmaceutical Care Center, 2155 Walker Building, Auburn, AL 36849. Your request must state how or where you would like to be contacted. We will accommodate all reasonable requests.

Receive written notification of a breach of your unsecured PHI. You have the right to receive written notification of a breach where your unsecured PHI has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and the breach compromises the security and privacy of your PHI. Unless specified in writing by you to receive this breach notification by electronic mail, we will provide this notification by first-class mail or, if necessary, by such other substituted forms of communication allowable under the law.

Examples of How We May Use and Disclose PHI

The following are descriptions and examples of ways we use and disclose PHI:

We will use PHI for treatment. Example: Information obtained by the pharmacist will be used to dispense prescription medications to you. We will document in your record information related to the medications dispensed to you and services provided to you.

We will use PHI for payment. Example: We will contact your insurer or pharmacy benefit manager to determine whether it will pay for your prescription and the amount of your copayment. We will bill you or a third-party payor for the cost of prescription medications dispensed to you. The information on or accompanying the bill may include information that identifies you, as well as the prescriptions you are taking.

We will use PHI for health care operations. Example: **Pharmacy Health Services** may use information in your health record to monitor the performance of the pharmacists providing treatment to you. This information will be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

We are likely to use or disclose PHI for the following purposes:

Business associates: There are some services provided by us through contracts with business associates. A few examples include:

- Pharmacy Health Services may contract with a firm to perform quality assurance surveys for the purpose of continuous quality improvement.

- Pharmacy Health Services may contract with software vendors to supply, maintain, and upgrade computer software used for dispensing and billing.

When these services are contracted for, we may disclose PHI about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payor for services rendered. To protect PHI about you, we require the business associate to appropriately safeguard the PHI.

Communication with individuals involved in your care or payment for your care: Health professionals such as pharmacists, using their professional judgment, may disclose to a family member, other relative, close personal friend or any person you identify, PHI relevant to that person's involvement in your care or payment related to your care.

Health-related communications: We may contact you to provide refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation: We may disclose PHI about you as authorized by and as necessary to comply with laws relating to worker's compensation or similar programs established by law.

Public health: As required by law, we may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose PHI about you for law enforcement purposes as required by law or in response to a valid subpoena or other legal process.

As required by law: We must disclose PHI about you when required to do so by law.

Health oversight activities: We may disclose PHI about you to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for our licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and administrative proceedings: If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

We are permitted to use or disclose PHI about you for the following purposes:

Research: We may disclose PHI about you to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, medical examiners, and funeral directors: We may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to carry out their duties.

Organ or tissue procurement organizations: Consistent with applicable law, we may disclose PHI about you to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Fundraising: We may contact you as part of a fundraising effort but you will be provided with an opportunity to opt out of any future such communications.

Notification: We may use or disclose PHI about you to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and your general condition.

Correctional institution: If you are or become an inmate of a correctional institution, we may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

To avert a serious threat to health or safety: We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and veterans: If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate military authority.

National security and intelligence activities: We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective services for the President and others: We may disclose PHI about you to authorized federal official so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Victims of abuse, neglect, or domestic violence: We may disclose PHI about you to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else or the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against you.

Other Uses and Disclosures of PHI

Pharmacy Health Services will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for above or as otherwise permitted or required by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you, except to the extent that we have already taken action in reliance on the authorization.

For More Information or to Report a Problem

If you have questions or would like additional information about Pharmacy Health Services' privacy practices, you may contact **Pharmacy Health Services Director** at **2155 Walker Building, Auburn, AL 36849; (334) 844-4099**. If you

believe your privacy rights have been violated, you can file a complaint with **Pharmacy Health Services Director** or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Effective Date

This Notice is effective as of **February 17, 2010.**

Pre-Participation Physical Evaluation Form

Date:	Name:		
Gender:	Age:	Date of Birth:	Phone:
Address:			
School:			
Sport:		Grade:	

Explain "Yes" answers below:	**Yes**	**No**
1. Has a doctor ever restricted/denied your participation in sports?	☐	☐
2. Have you ever been hospitalized or spent a night in a hospital?	☐	☐
a. Have you ever had surgery	☐	☐
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?	☐	☐
4. Are you presently taking any medications or pills (prescription or over-the-counter?)	☐	☐
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	☐	☐
6. Have you ever passed out during or after exercise?	☐	☐
a. Have you ever been dizzy during or after exercise?	☐	☐
b. Have you ever had chest pain or discomfort in your chest during or after exercise?	☐	☐
c. Do you tire more quickly than your friends during exercise?	☐	☐
d. Have you ever had high blood pressure?	☐	☐
e. Have you ever been told you have a heart murmur, high cholesterol, or heart infection?	☐	☐
f. Have you ever had racing of your heart or skipped heartbeats?	☐	☐
g. Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
h. Does anyone in your family have a heart condition?	☐	☐
i. Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	☐	☐
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	☐	☐
8. Have you ever had a head injury or concussion?	☐	☐
a. Have you ever been knocked out or unconscious?	☐	☐
b. Have you ever had a seizure?	☐	☐
c. Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?	☐	☐
9. Have you ever had heat or muscle cramps?	☐	☐
a. Have you ever been dizzy or passed out in the heat?	☐	☐
10. Do you have trouble breathing or do you cough during or after activity?	☐	☐
a. Do you take any medications or use an inhaler for asthma?	☐	☐
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	☐	☐
12. Have you had any problems with your eyes or vision?	☐	☐
a. Do you wear glasses, contacts or protective eye wear?	☐	☐

13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	☐	☐
14. Have you had a medical problem or injury since your last evaluation?	☐	☐
15. Have you ever been told you have sickle cell trait?	☐	☐
Has anyone in your family had sickle cell disease or sickle cell trait?	☐	☐
16. Have you ever sprained/ strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ☐ Head ☐ Back ☐ Shoulder ☐ Forearm ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Neck ☐ Chest ☐ Elbow ☐ Wrist ☐ Finger ☐ Thigh ☐ Shin ☐ Foot	☐	☐
17. When was your first menstrual period? _____ When was your last menstrual period? _____ What was the longest time between your periods last year? _____		
Explain any "Yes" answers: _____ _____ _____ _____		

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of athlete _____ Date _____

Signature of parent/ guardian _____ Date _____

Duplicate as needed