

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, June 25th from 8:30am-11:00am, Irene New Gym**
- 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:

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 _____		Soc. Sec. # _____	
Legal name _____	Last _____	First _____	Middle initial _____
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 _____		City _____ State _____ Zip _____	
Street _____ PO Box _____			
Home phone () _____		Work phone () _____ Cell phone () _____	
Employer _____		Occupation _____	
Employer address _____		City _____ State _____ Zip _____	
Street _____ PO Box _____			
Spouse's name _____		Birth date _____ Soc. Sec. # _____	
Employer _____		Occupation _____	
Work phone () _____		Cell phone () _____	
Employer address _____		City _____ State _____ Zip _____	
Street _____ PO Box _____			
RESPONSIBLE PARTY / BILLING INFORMATION (If patient is a minor)			
Mother's name _____		Birth date _____ Soc. Sec. # _____	
Address _____		Home phone () _____	
Street _____ PO Box _____ City _____ State _____ Zip _____		Work phone () _____	
Employer _____		Cell phone () _____	
Occupation _____			
Employer address _____		City _____ State _____ Zip _____	
Street _____ PO Box _____			
Father's name _____		Birth date _____ Soc. Sec. # _____	
Address _____		Home phone () _____	
Street _____ PO Box _____ City _____ State _____ Zip _____		Work phone () _____	
Employer _____		Cell phone () _____	
Occupation _____			
Employer address _____		City _____ State _____ Zip _____	
Street _____ PO Box _____			
EMERGENCY CONTACT			
Name _____		Relationship to patient _____	
Address _____		City _____ State _____ Zip _____	
Street _____ PO Box _____			
Home phone () _____		Work phone () _____ Cell phone () _____	



PIONEER MEMORIAL
VIBORG MEDICAL CLINIC

PATIENT INFORMATION
VMC 2005
Revised 3/8/2022

NAME _____
DOB _____

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 PMHHS 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 of 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.

Signature of Patient or Authorized Person

Date

Time

a.m./p.m.

Relationship to Patient (if not patient signing)



PIONEER MEMORIAL
VIBORG MEDICAL CLINIC

STATEMENT OF FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

VMC 2005
Revised 3/8/2022

Patient Name _____

DOB _____

SDHSAA CONSENT FOR PARTICIPATION IN ACTIVITIES

Student Name: _____

Date of Birth: _____

School Year: 2025-26 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 2025-26 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, 2026.
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, 2026)

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 your 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 traumatic brain injury that interferes with the normal function of the brain.

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.

Signs Observed By Parents or Guardians	Symptoms Reported by Athlete
• Dazed, vacant, or stunned appearance • Is confused about assignment or position • Forgetfulness • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Shows mood, behavior, or personality changes • Can't recall events prior to or after hit or fall	• Headache or "pressure" in head • Neck pain • Nausea • 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?

If your child sustains a head injury, it is good to be aware of the signs and symptoms of a concussion. If you suspect an athlete has a concussion, the athlete must be removed from activity. Do not allow the athlete to drive until symptoms have resolved. Continuing to participate in a contact or collision sport while experiencing concussion symptoms can lead to worsening of symptoms, increased risk of further injury, and sometimes death.

Parents and coaches should not make the diagnosis of a concussion. Any athlete suspected of having a concussion should be evaluated by a medical professional trained in the diagnosis and management of concussions.

WHEN IN DOUBT, SIT THEM OUT!

_____ 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	BONE AND JOINT QUESTIONS, CONTINUED:	Yes	No
1. Do you have any concerns you'd like to discuss with your provider?			15. Do you have a bone, muscle, ligament or joint injury that bothers you?		
2. Has a provider ever denied or restricted your participation in sports for any reason?			MEDICAL QUESTIONS	Yes	No
3. Do you have any ongoing medical issues or recent illnesses?			16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	17. Are you missing a kidney, an eye, a testicle, your spleen or any other organ?		
4. Have you ever passed out or nearly passed out during or after exercise?			18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
5. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?			19. Do you have recurring skin rashes or rashes that come and go, including herpes or MRSA?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?			20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?		
7. Has a doctor ever told you that you have any heart 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?		
8. Has a doctor ever requested a test for your heart? (Example: electrocardiography or echocardiography)			22. Have you ever become ill while exercising in the heat?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			23. Do you or does someone in your family have sickle cell trait or disease?		
10. Have you ever had a seizure?			24. Have you ever had, or do you have any problems with your eyes or vision?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	25. Do you worry about your weight?		
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)			26. Are you trying to, or has anyone recommended that you gain or lose weight?		
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 (CPVT)?			27. Are you on a special diet, or do you avoid certain types of foods or food groups?		
13. Has anyone in your family had a pacemaker or implanted defibrillator before age 35?			28. Have you ever had an eating disorder?		
BONE AND JOINT QUESTIONS	Yes	No	29. Have you ever had COVID-19?		
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?			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: _____

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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.

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