Delta Health Center, Inc.
102 MLK Drive Indianola, MS
662-445-0900

**PLEASE COMPLETE ENTIRELY FRONT AND BACK: RETURN TO SCHOOL TOMORROW**

**Child's Name: _____ Date of Birth: _____ Age: _____**

**School Name: _____ Teacher: _____ Grade: ____**

**Address: _____ Home Phone: _____**

**Parent/Guardian Name: _____ Phone Number: _____**

**Family Physician: _____**

**DAILY MEDICATIONS: [ ] None or List _____**

**MEDICATION OR FOOD ALLERGIES: [ ] None or List _____**

**CURRENT HEALTH PROBLEMS: [ ] None or List _____**

**PAST MEDICAL HISTORY: [ ] None or List _____**

**INSURANCE NAME: _____ INSURANCE ID #: _____**

**Your child's school has a contract with Delta Health Center, Inc to complete your child's medical screening. All services are provided to all children regardless of insurance. If you have any questions please call 662-741-8800.**

**You will NOT receive a bill for any of our services but you may receive an explanation of benefits from your insurance company which is NOT A BILL.**

****** To the best of my knowledge, I have given true and accurate information and Yes, I hereby grant permission for the medical screening evaluation.***

**Parent/Guardian Signature: _____ Date: _____**

Information below to be completed by Delta Health Center Staff

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Temp: _____

| | Normal | Abnormal | | Normal | Abnormal | Flexibility |
|---|---|---|---|---|---|---|
| ENT | ____ | ____ | Cervical Spine | ____ | ____ | Neck ____ |
| Heart | ____ | ____ | Thoracic Spine | ____ | ____ | Back ____ |
| Lungs | ____ | ____ | Lumbar Spine | ____ | ____ | Upper Extremity: Right ____ Left ____ |
| Skin | ____ | ____ | Upper Extremity | ____ | ____ | Lower Extremity: Right ____ Left ____ |
| Abdomen | ____ | ____ | Lower Extremity | ____ | ____ | |
| Hernia | ____ | ____ | | | | |

Comments/Concerns: _____

{ } From the limited screening I see NO reason why this student cannot participate in athletics

{ } Student needs further evaluation as described

_____ _____ _____

Name of Provider Signature Date



***COMPLETE BACK PAGE!***

*"Health Care with Care"*

*Since 1965*

**THIS FORM HAS TO BE SIGNED AND TURNED BACK IN TO YOUR CHILD'S SCHOOL IN ORDER FOR YOUR CHILD TO BE SEEN.**

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY AND CONSENT TO USE/DISCLOSE HEALTH INFORMATION**

I acknowledge that I have received a copy of Delta Health Center's Notice of Privacy Practices. I understand that as part of my healthcare, DHC originates and maintains health records describing child's health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my child's care and treatment
- A means of communication among many healthcare professionals who contribute to my child's care
- A source of information for applying my child's diagnosis to any bill
- A means by which reimbursement agencies can certify that services billed were actually provided, and
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of the healthcare professionals

I request the following restrictions to the use of disclosure of my child's health information:

_____

_____

_____

I hereby authorize a member of Delta Health Center, Inc. and South Sunflower Consolidated School District to exchange health and education/records.

Child's Name: _____

_____ _____

Signature of Parent/Legal Guardian/Relation Date



***COMPLETE BACK PAGE!***