Boone County Health Center & Medical Clinics Sports Physical Consent Form

PLEASE PRINT LEGIBLY

Patient Name: _____ _____ _____
(Last) **(First)** **(Initial)**

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Phone Number: _____ **Date of Birth:**_____

Male: ( ) **Female: ( )**

Ethnicity (Check One): [ ] Not Hispanic or Latino [ ] Hispanic or Latino [ ] Unknown

Race (Check One): [ ] White [ ] American Indian/Alaskan Nation [ ] Asian [ ] Hispanic [ ] Black or African American [ ] Native Hawaiian or other Pacific Island [ ] Unknown

Guarantor/Guardian: Person responsible for this patient's bills.

_____ _____
Last Name, First Name, Middle Initial) Relationship to Patient

_____
Address (Street, City, State, Zip)

_____ _____
Date of Birth Phone Number

Employment Status: (Circle one) Full-time Part-time Self Retired Disabled Not Employed

Employer's Name_____

Employer's Address_____

Employer's Phone Number_____

My signature below authorizes Boone County Health Center & Medical Clinics to perform a sports physical on my son/daughter. I understand that this will not be submitted to my insurance and I will be expected to pay $25 for this examination.

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

Boone County Health Center use only:

[ ] Cash
[ ] Check Check Number: _____

FIN Number: _____

Clinic Nurse Use Only:

Physical Done at:

[ ] Boone County Medical Clinic
[ ] Elgin Veterans' Medical Clinic
[ ] Nance County Medical Clinic
[ ] Newman Grove Medical Clinic
[ ] Spalding Medical Clinic