EVERY DAY

May 13-17

@ Lapwai Elementary School

Healthy, Happy YOU!

No cost healthcare provided by the Idaho National Guard. **All Ages. Tribal Membership Not Required.**

Bring your family and **receive any of the following treatments below at no cost** Then, enjoy evening activities with the Idaho National Guard Team.

Eye Check

- Optometry check-up

Dental Care

- Dental Exams
- Dental sealants
- Simple Treatments

General Health

- Diabetic/Asthma/ Cardiovascular Exams
- Department of Transportation and Sports Physicals
- Annual Physicals
- Immunizations

For more information contact Cara at 208.621.4964 or caraw@nimiipuu.org

Nimiipuu Health Medical History Form

Patient's Name LAST FIRST MIDDLE INITIAL	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	Patient's Grade Level
Phone Home Work		Sex M F

Have you (the parent/guardian) or the patient had any of the following diseases or problems?..... Y N
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

Anemia ……..Y N Cancer……..Y N Ear Aches……...Y N HIV/AIDS……Y N Mononucleosis……..Y N Thyroid…..Y N
Cerebral Palsy…..Y N Fainting……Y N Immunizations……Y N Mumps……Y N Tobacco/Drug Use…Y N Asthma…..Y N
Growth Problems..Y N Kidney……...Y N Pregnancy (teens)..Y N Tuberculosis..Y N Bladder……...Y N Sickle cell..Y N
Hearing…….. Y N Chicken Pox……Y N Hepatitis……Y N Arthritis……...Y N Chronic Sinusitis……Y N Measles…Y N
Latex allergy……..Y N Rheumatic Fever.Y N Bleeding disorders.Y N Diabetes……Y N Heart……Y N Sexually Transmitted Infection..Y N
Liver……Y N Seizures……Y N Bones/Joints……Y N Other_____

Please list the name and phone number of the child's medical provider:

Name of Provider_____Phone _____

Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... Y N

If yes, please list:_____

Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____ Y N

Is the child allergic to anything else, such as certain foods? If yes, please explain: _____ Y N

Has the child ever had a serious illness? If yes, when: _____ Please describe: _____ Y N

Has the child ever been hospitalized? If yes, when: _____ Please describe: _____ Y N

Does the child have a history of any other illnesses? If yes, please list: _____ Y N

Is the child physically, mentally, or emotionally impaired?..... Y N

Does the child experience excessive bleeding when cut?..... Y N

Has the child had any problem with dental treatment in the past? ..... Y N

Has the child ever suffered any injuries to the mouth, head or teeth? ..... Y N

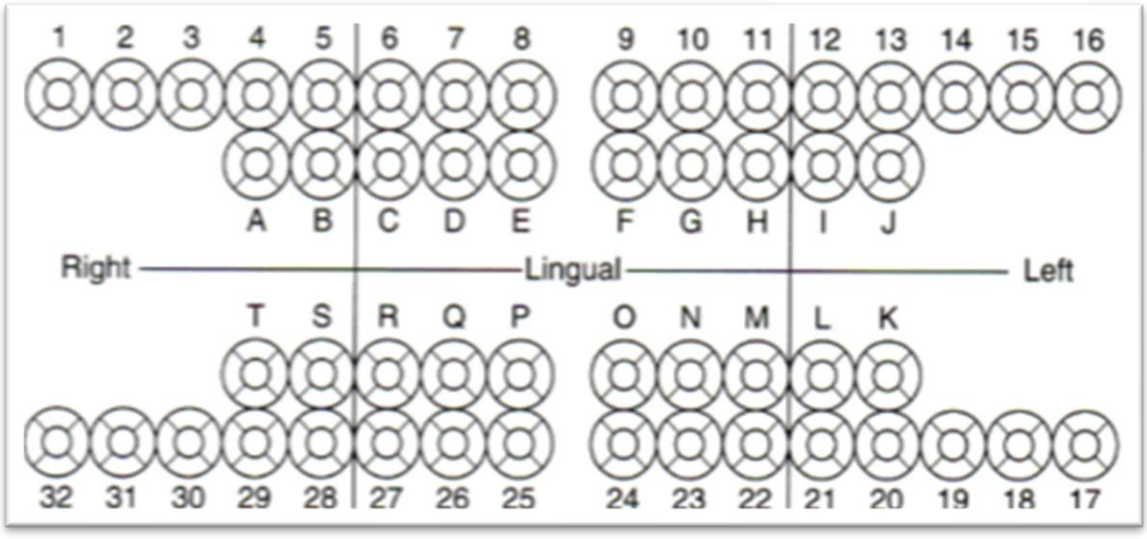
Please provide Immunizations as needed for my child? ..... Y N

The answers I have given are true to the best of my knowledge. I am indicating consent for routine procedures such as; [ ] **immunizations [ ],sports physicals[ ], Optical [ ], x-rays [ ], fluoride [ ], fillings [ ], and simple extractions of primary teeth[ ]**. Dental anesthetic (topical or local) is commonly used to provide comfort during dental care. It is safe but has certain risks. Common risks are bruising, swelling, or pain at the site of the injection. A temporary rapid heartbeat sometimes occurs. Permanent numbness or abnormal sensations rarely occur. I consent to the use of anesthetic for dental care.

Parent's/Guardian's Signature_____Date_____

Provider's Signature_____Date_____

☐ **Yes, I approve National Guard medical services May13-17, 2024 _____ Date:_____**



Media Release Form
Nimiipuu Health

I, _____, hereby grant permission to Nimiipuu Health and/or the United States National Guard, the rights of my image, in video or still, and the likeness and sound of my voice as recorded on audio or video. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive the right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for ANY USE which may include but is not limited to:

- Presentations
- Courses
- Online/Internet Videos
- Media
- Social Media
- News (Press)

By signing this release, I understand this permission signifies that photographic or video recordings of me may be displayed via the Internet or in a public educational setting.
I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed for use in an any setting.

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material.

Full Name-Printed (Parent/Guardian if under 18):_____

Minor Full Name-Printed:_____

Phone Number and/or Email:_____

Email Address:_____

Signature (Parent/Guardian if under 18) _____ Date_____

sIDAHO HIGH SCHOOL ACTIVITIES ASSOCIATION
IDAHO HEALTH EXAMINATION AND CONSENT FORM

It is required that all students complete a History and Physical examination prior to his/her first 9th and 11th grade practice in the interscholastic (9-12) athletic program in the State of Idaho. The exam is at the expense of the student and may not be taken prior to May 1 of the 8th and 10th grade years. This examination is to be done by a licensed physician, physician's assistant or nurse practitioner under optimal conditions. Interim history forms are required during the 10th and 12th grade years and must be submitted to the principal prior to the first practice.

Name _____ Home Address _____Phone _____
Grade _____ Sports _____
Personal Physician _____ Physician's phone number _____
Date of Birth _____ Sex _____ School _____

HISTORY FORM

*Fill in details of "YES" answers in space below:

	YES	NO
1. A. Have you ever been hospitalized?	____	____
B. Have you ever had surgery?	____	____
2. Are you presently taking any medication or pills?	____	____
3. Do you have any allergies (medicine, bees, other stinging insects)?	____	____
4. A. Have you ever passed out during or after exercise?	____	____
B. Have you ever been dizzy during or after exercise?	____	____
C. Have you ever had chest pain during or after exercise?	____	____
D. Do you tire more quickly than your friends during exercise?	____	____
E. Have you ever had high blood pressure?	____	____
F. Have you ever been told you have a heart murmur?	____	____
G. Have you ever had racing of your heart or skipped beats?	____	____
H. Has anyone in your family died of heart problems or a sudden death before age 50?	____	____
5. Do you have any skin problems? (itching, rash, acne)	____	____
6. A. Have you ever had a head injury?	____	____
B. Have you ever been knocked out or unconscious?	____	____
C. Have you ever had a seizure?	____	____
D. Have you ever had a stinger, burner, or pinched nerve?	____	____
7. A. Have you ever had heat cramps?	____	____
B. Have you ever been dizzy or passed out in the heat?	____	____
8. Do you have trouble breathing or cough during or after exercise?	____	____
9. Do you use special equipment, pads, braces, mouth or eyeguards?	____	____
10. A. Have you had problems with your eyes or vision?	____	____
B. Do you wear glasses, contacts or protective eyewear?	____	____

11. Have you ever sprained/strained, dislocated, fractured/broken, or had repeated swelling or other injuries of any of your bones or joints?

____ Head	_____ Neck	_____ Chest	_____ Back	_____ Hip
_____Shoulder	_____ Elbow	_____ Forearm	_____ Wrist	_____ Hand
____ Thigh	_____ Knee	_____ Shin/Calf	_____ Ankle	_____ Foot

12. Have you ever had any other medical problems such as:

____ Mononucleosis	_____ Diabetes	_____ Asthma	_____ Hepatitis	_____ Headaches (frequent)
____ Tuberculosis	_____ Eye injuries	_____ Stomach ulcer	_____ Other	

13. Have you had a medical problem or injury since last exam? _____
14. When was your last tetanus shot? _____
When was your last measles immunization? _____
15. When was your first menstrual period? _____ When was your last menstrual period? _____
What was the longest time between periods last year? _____

*Explain "YES" answers here: _____

CONSENT FORM

(Parent or Guardian and Student Permission and Approval)

I hereby consent to the above named student participating in the interscholastic athletic program at his/her school of attendance. This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated by school authorities for any illness or injury resulting from his/her athletic participation. In the absence of parents, I also consent to the release of any information contained in this form to carry out treatment and health care operations for the above named student.

PARENT OR GUARDIAN SIGNATURE _____ DATE: _____

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the State Association.

SIGNATURE OF STUDENT _____ DATE: _____

PHYSICAL EXAMINATION FORM

Height _____ Weight _____ BP _____/_____ T_____ Pulse _____ R _____
Visual acuity R 20 / _____ L 20 / _____ Corrected: Y N Pupils _____

	Normal	Abnormal
Ears, Nose, Throat	_____	_____
Cardiopulmonary		
Pulses	_____	_____
Heart	_____	_____
Lungs	_____	_____
Skin	_____	_____
Abdominal	_____	_____
Genitalia	_____	_____
Musculoskeletal	_____	_____
Neck	_____	_____
Shoulder	_____	_____
Elbow	_____	_____
Wrist	_____	_____
Hand	_____	_____
Back	_____	_____
Knee	_____	_____
Ankle	_____	_____
Foot	_____	_____

CLEARANCE / RECOMMENDATIONS

Clearance:

_____ A. Cleared for all sports and other school-sponsored activities.

_____ B. Cleared after completing evaluation / rehabilitation for:
_____

_____ C. *NOT* cleared to participate in the following IHSAA sponsored sports:
Baseball Cross Country Golf Softball Track
Wrestling
Basketball Football Soccer Tennis
Volleyball
Not cleared for other school-sponsored activities:
(Example) 1. Swimming 2. _____ 3. _____

_____ D. Student is *NOT* permitted to participate in high school athletics. Reason: _____
_____
_____

Recommendation: _____
_____

Examiner's Signature: _____ Date: _____
(This Physical form must be signed by a licensed physician, physician's assistant or nurse practitioner)

Address: _____ Phone: (_____) _____