From: Delfina Lisondra
To: DSAROMI
Subject: RE: athletic form, Jasmine Lisondra
Date: Thursday, October 25, 2018 1:48:25 PM
Attachments: [Untitled].pdf

Here you go.

Delfina Lisondra

From: DSAROMI [mailto:DSAROMI@kp.org]
Sent: Thursday, October 25, 2018 1:38 PM
To: Delfina Lisondra
Subject: RE: athletic form, Jasmine Lisondra

Hello,
In order to process your request, please complete the patient information on the form including answering all questions on Page 1 and resubmit.

Thank you,
ROMI Clerks
-MSA

From: Delfina Lisondra <Delfina.Lisondra@clorox.com>
Sent: Thursday, October 25, 2018 8:56 AM
To: DSAROMI <DSAROMI@kp.org>
Cc: Delfina Lisondra <Delfina.Lisondra@clorox.com>
Subject: athletic form, Jasmine Lisondra
Importance: High

Hello
Please find attached an athletic form I need signed for my daughter, Jasmine Lisondra.
Her medical number is: 11956863
Her doctor is: Dr. Smith

Thank you in advance,
Delfina Lisondra
925-980-8260

THIS QUESTIONAIRE IS FOR PATIENT'S MEDICAL RECORD ONLY DO NOT RETURN TO SCHOOL
PLEASE FILL OUT PRIOR TO YOUR APPOINTMENT

SPORTS PHYSICAL PHYSICIAN OFFICE FORM

Name: Jasmine Lisondra Date of Birth: 11-27-02 Student ID: 1018769

Sports: Basketball School: Granada Grade: 11 Male ☐ Female ☒

EXPLAIN YES ANSWERS BELOW CIRCLE QUESTIONS YOU DO NOT UNDERSTAND

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports?	☐	☑
2. Do you have a medical condition (asthma/diabetes)?	☐	☑
CARDIAC RISK:		
1. Has any relative died of a heart condition suddenly before age 50?	☐	☑
2. Do you or your relatives have a history of:		
a. Heart muscle disease such as hypertrophic cardiomyopathy?	☐	☑
b. Arrhythmia, irregular rhythm, pacemaker WPW (Wolf Parkinson White), Long QT syndrome or other cardiac problem?	☐	☑
c. Marfan Syndrome?	☐	☑
3. Does your heart race or skip beats during exercise?	☐	☑
4. Have you ever had chest pain during exercise?	☐	☑
5. Have you ever passed out or nearly passed out during or after exercise?	☐	☑
6. Do you have a history of high blood pressure?	☐	☑
7. History of a heart murmur (other than innocent murmur) or other heart problem?	☐	☑
8. History of unexplained dizziness with exercise?	☐	☑
9. Have you ever had an ECG or Echocardiogram test for your heart?	☐	☑
10. History of congenital heart disease?	☐	☑
11. History of Carditis or Kawasaki disease?	☐	☑
RESPIRATORY RISK:		
1. History of cough, wheezing, or difficulty breathing during or after exercise?	☐	☑
2. Have you ever used an inhaler or taken asthma medication?	☐	☑
3. Do you have a history of severe allergies to pollens, stinging insects, foods, or grasses?	☐	☑
4. Have you ever been told by a doctor that you have asthma?	☐	☑
5. History of fractured ribs in the last 6 weeks?	☐	☑
NEUROLOGICAL RISK:		
1. History of head or neck injury, or concussion?	☐	☑
2. Have you ever had amnesia or memory loss after a head injury?	☐	☑
3. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or or falling?	☐	☑
4. History of seizures?	☐	☑
5. History of headaches with exercise?	☐	☑
6. Do you have a history of any problems with your eyes or vision?	☐	☑
7. Do you wear glasses or contact lenses?	☐	☑
8. History of neck instability (i.e. Atlantoaxial Instability)	☐	☑

INFECTION RISK:	Yes	No
1. Do you have a history of recurrent or persistent rashes, pressure sores, herpes, or other skin infections?	☐	☑
2. Have you ever been diagnosed or treated for a MRSA infection?	☐	☑
3. History of Mono (EBV) in the last 4 weeks?	☐	☑
4. History of recurrent unexplained fevers, or chronic coughing?	☐	☑
5. Do you or any members of your household have a history of tuberculosis or positive PPD?	☐	☑
6. History of Hepatitis?	☐	☑
7. History of HIV?	☐	☑
ORTHOPEDIC RISK:		
1. Have you ever broken any bones?	☐	☑
2. History of neck or back injury?	☐	☑
3. History of chronic back or neck pain?	☐	☑
4. History of ankle, knee, hip injury?	☐	☑
5. History of wrist, elbow, shoulder injury?	☐	☑
6. Do you have any artificial limbs or prosthetic devices (false teeth)?	☐	☑
OTHER PERTINENT QUESTIONS:		
1. Are you taking any prescription or nonprescription (over the counter) medicines or pills?	☐	☑
2. Are you taking supplements or medications to gain or lose weight?	☐	☑
3. Are you taking medications or supplements to increase your strength or improve your sports performance?	☐	☑
4. Are you trying to gain or lose weight?	☐	☑
5. Were you born without or are you missing a kidney, eye, (if male testicle), (if female ovary) or other organ?	☐	☑
6. History of bleeding or clotting disorder?	☐	☑
7. History of severe muscle cramps or feeling severely ill when exercising in the heat?	☐	☑
8. History of surgery?	☐	☑
9. History of enlarged liver or spleen?	☐	☑
10. History of sickle cell disease/trait?	☐	☑
11. History of Hypoglycemia (low blood sugar)?	☐	☑
Any medical changes since your last physical ?	☐	☑
FEMALES OLDER THAN 16 (OPTIONAL)		
Have you had no periods?	☐	☐
Have you gone more than 90 days without a period in the last 6 months?	☐	☐

Explain "YES" answers here: _____

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

Signature of athlete: Jasmine Lisondra **Signature of parent/guardian:** _____ **Date** 10/25/18

KAISER PERMANENTE

PEDIATRIC SPORTS FORM
FOCUSED RISK HISTORY QUESTIONNAIRE

DATE	MEDICAL RECORD #
10/26/18	11956863
NAME Lisondra, Jasmine	**PHONE** 925 980-8260

SINCE YOUR **LAST WELL CHECK** HAVE YOU EXPERIENCED:	Yes	No
1. Health concerns or injuries?		X
2. Pain in your back, legs, or arms that keeps coming back?		X
3. Limited range of motion (not able to fully bend, extend, or twist?)		X
4. Tightness, pain, or pressure in your chest, or trouble breathing during exercise?		X
5. Passed out or nearly passed out during exercise?		X
6. A concussion (hit or blow to your head that caused any of the following: Confusion, Lasting Headache, Sleep or Memory Problems?		X
7. Heat stroke or heat exhaustion (severely ill while exercising in the heat)?		X
8. A family member died of heart problems such as a heart attack or arrhythmia or had an unexpected or unexplained death before age 50?		X
9. Any injuries that were seen by a doctor outside of Kaiser Permanente?		X
10. Do you have any uncontrolled medical problems that require medications? If yes, please list medical problems:		X

For office use only

Positive questions reviewed and cleared ☐ Notes:

Positive questions reviewed and not cleared. Appointment to be booked by clinic ☐

Immunizations

Never Reviewed

Name	Date	Dose	VIS Date	Route
DTaP (Diphtheria, Tetanus, acellular Pertussis)	7/19/2007 12:00 AM (4 Y)	--	--	--
DTaP (Diphtheria, Tetanus, acellular Pertussis)	7/25/2006 12:00 AM (3 Y)	--	--	--
DTaP (Diphtheria, Tetanus, acellular Pertussis)	6/20/2003 12:00 AM (6 M)	--	--	--
DTaP (Diphtheria, Tetanus, acellular Pertussis)	3/21/2003 12:00 AM (3 M)	--	--	--
DTaP (Diphtheria, Tetanus, acellular Pertussis)	1/21/2003 12:00 AM (7 W)	--	--	--
HAV ped/adol 2 dose sch (Hepatitis A)	7/19/2007 12:00 AM (4 Y)	--	--	--
HAV ped/adol 2 dose sch (Hepatitis A)	7/25/2006 12:00 AM (3 Y)	--	--	--
HBV (Hepatitis B)	2/14/2003 12:00 AM (11 W)	--	--	--
HBV (Hepatitis B)	11/28/2002 12:00 AM (1 D)	--	--	--
HIB (Haemophilus influenzae b)	6/20/2003 12:00 AM (6 M)	--	--	--
HIB (Haemophilus influenzae b)	3/21/2003 12:00 AM (3 M)	--	--	--
HIB (Haemophilus influenzae b)	1/21/2003 12:00 AM (7 W)	--	--	--
HIB prp-omp-HBV (Haemophilus influenzae b, Hepatitis B)	12/22/2003 12:00 AM (12 M)	--	--	--
HPV4 (Human papillomavirus, quadrivalent) Site: LEFT DELTOID Given By: Herrera, Francisca Fernandez (L.V.N.) Manufacturer: Merck and Co., Inc. Lot: K014191 VIS 4/IMINT	6/11/2015 12:00 AM (12 Y)	00.50	--	Intramuscular
HPV9 (Human Papillomavirus) 9 valent Site: LEFT DELTOID Given By: Geronimo, Ginelle (L.V.N.) Manufacturer: Merck and Co., Inc. Lot: M009362	7/1/2016 10:12 AM (13 Y)	0.5 mL	3/31/2016	Intramuscular
HPV9 (Human Papillomavirus) 9 valent Site: LEFT DELTOID Given By: Van Airsdale, Brittney Joy (L.V.N.) Manufacturer: Merck and Co., Inc. Lot: L019287	9/2/2015 3:44 PM (12 Y)	0.5 mL	4/15/2015	Intramuscular
MENcn-ACYW (Meningococcal conjugate, groups ACYW-135) Site: LEFT DELTOID Given By: Herrera, Francisca Fernandez (L.V.N.) Manufacturer: Aventis Pasteur Lot: U5026AA	6/11/2015 12:00 AM (12 Y)	00.50	--	Intramuscular
MMR (Measles, Mumps, Rubella)	7/19/2007 12:00 AM (4 Y)	--	--	--
MMR (Measles, Mumps, Rubella)	12/22/2003 12:00 AM (12 M)	--	--	--
PNUcn (Pneumococcal conjugate, pneumonia)	6/20/2003 12:00 AM (6 M)	--	--	--
PNUcn (Pneumococcal conjugate, pneumonia)	3/21/2003 12:00 AM (3 M)	--	--	--
PNUcn (Pneumococcal conjugate, pneumonia)	1/23/2003 12:00 AM (8 W)	--	--	--
POL-IPV (Polio, Inactivated virus)	7/19/2007 12:00 AM (4 Y)	--	--	--
POL-IPV (Polio, Inactivated virus)	12/22/2003 12:00 AM (12 M)	--	--	--
POL-IPV (Polio, Inactivated virus)	3/21/2003 12:00 AM (3 M)	--	--	--
POL-IPV (Polio, Inactivated virus)	1/21/2003 12:00 AM (7 W)	--	--	--

Immunizations (continued)

Never Reviewed

Name	Date	Dose	VIS Date	Route
Tdap (BOOSTRIX) (Tetanus, diphtheria, acellular pertussis) Site: LEFT DELTOID Given By: Baker, Patricia K (L.V.N.) Manufacturer: GlaxoSmithKline Lot: 4327T VIS5/9	6/2/2014 12:00 AM (11 Y)	00.50	--	Intramuscular
VAR (Varicella, chickenpox) Site: LEFT ARM Given By: Baker, Patricia K (L.V.N.) Manufacturer: Merck and Co., Inc. Lot: 0269X	8/13/2008 (5 Y)	00.50	--	Subcutaneous
VAR (Varicella, chickenpox)	12/22/2003 (12 M)	--	--	--

PPD/Skin Test - PPD Results Key: 00 = Negative 01 = Positive

There is no flowsheet data to display.

SPORTS PHYSICAL SCHOOL FORM

I grant permission to release the information below to School Personnel.

Signature of Parent/Guardian: _____ Medical Insurance Co. 11956863

NAME: Jasmine Lisondra Date of Birth: 11-27-02 Student ID: _____

Sports: Basketball School: Granada Grade: 11

Emergency Contact: Delfina Lisondra Cell Phone: 925-980-8260 Home Phone: 925 980 8485

ALLERGIES: None MEDICATIONS: None.

DATE OF EXAM: 10/06/2018 Height: 4'11.5" Weight: 110 lbs BMI: 21.91 Pulse: 61 BP: 109/71

HEARING: ☒ Passed Right/Left ≤25dcbls (all frequencies) VISION: R 20/ 25 L 20/ 25 Both 20/ ___ Corrected: ☐Y ☒N

☐ Failed _____ ☐ Not Done U/A: ☐ Normal ☐Y ☐N _____

REQUIRED IMMUNIZATIONS: Measles, Mumps Rubella, Hepatitis B, Polio, Tetanus, and Pertussis.

☐ ☐Received Varicella Vaccine/ or Varicella illness after 1 yr. of age Date of Last Tdap: 06/02/2014

☐ ☐Up to date (See Attached Vaccine Documentation) ☐☐ Not up to Date, Vaccines Needed: _____

☐BASELINE CONCUSSION ASSESSMENT COMPLETED – Optional, but highly recommended

Date: _____ Tool Used: ImPACT / SCAT2 / SAC / Other _____

MEDICAL:	NORMAL	ABNORMAL FINDINGS
General Appearance	X	
Head eyes/ears/nose/throat		
Neck		
Respiratory		
Heart		
Pulses		
Abdomen		
Skin		
Neuro		
Lymph Nodes		
Genitourinary (males only)	N/A	

MUSCULOSKELETAL:	NORMAL	ABNORMAL FINDINGS
Back (including scoliosis screen)	X	
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

Assessment/Plan: _____ OFFICE STAMP:

Kaiser Permanente
Release of Information Clerk
320 Lennon Lane
Walnut Creek, CA 94598

☒Cleared for all sports without restrictions

☐ Not Cleared for ☐All sports ☐Certain sports _____

Reason: _____

☐ Deferred requires further evaluation (See Recommendations Below):

☐ Cleared with restrictions (See Recommendations Below):

Recommendations: _____

Name of Physician (print) Smith, Yineth Rocio (M.D.) Address: 320 LENNON LN WC,CA 94598 Phone: (925) 817-5661

Signature of Physician: Yineth R. Smith, M.D. , M.D., D.O., or N.P. Date: 10/26/18

JACQUI WALKER AUTH SIGNER FOR Smith, Yineth Rocio (M.D.)

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine. Rev. May 2012