

SPORT PHYSICAL CLINIC

provided by

Edmonds Family Medicine

EFM providers and nursing staff are generously donating sport physical exams for the students of Edmonds School District!



Did you know?? Edmonds School District requires all student-athletes to have a sports physical exam every 24 months. We can help!

- Available to students in grades 6th – 12th with no physical, or a sport physical expiring in the next 12 months
- **Appointments are preferred, but walk-ins are welcome**
- A signed consent form is **required** in order to receive the sport exam

Email lewisc040@edmonds.wednet.edu to schedule an appointment.

*Appointment will not be confirmed until the office receives the **Parent Consent Form***

WHEN: May 26th 2:30PM-5PM

WHERE: Edmonds-Woodway High School
7600 212th St. S.W. Edmonds, WA 98026

COST: Suggested \$20 donation for the EW Sport Medicine Program, but not required
Make checks payable to ESD, Edmonds School District





Paul Bagnulo MD
Ann Begert MD
Martha S Bennett MD
Robert Bettis MD
Ginger Blakeney MD
Sandra Borg MD
Ross Carey MD

Stephen Carter MD
Mark Hanson MD
Rachel Hollister MD
Myra Horiuchi MD
Mary Jo Kintner MD
Donald Moe MD
Joseph Petrin MD

Martin Proudfoot MD
Susanne Quistgaard MD
Christopher Sargent MD
Jae Sim MD
David Taibleson MD
Donald Tesch MD
Andrew Thurman MD

Mary Ellen Tolberg MD
Daniel Weakly MD
Shawn West MD
Angela Yue MD
Kelly Yukevich ARNP
Marcy Shimada CEO

Consent to Medical Care and Treatment of Minor Children

I, _____, the natural parent/ legal guardian of: _____, authorize and consent to have the following medical care delivered in my absence at Edmonds Family Medicine Clinic.

<ul style="list-style-type: none"> • Allergy injections <input type="checkbox"/> • Emergent care (sutures, casts, etc.) <input type="checkbox"/> • F/U care e.g.: my son or daughter may be seen without me for routine care and follow up appointments <input type="checkbox"/> • School and/or sports <input checked="" type="checkbox"/> 	<ul style="list-style-type: none"> • Suture removal <input type="checkbox"/> • Medication Administration <input type="checkbox"/> • Immunizations <input type="checkbox"/> • X-rays <input type="checkbox"/> • Laboratory studies <input type="checkbox"/>
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I hereby agree to accept responsibility for any financial indebtedness incurred, at the physicians' office. I agree to pay all necessary services at the current rate.

Child's Name: _____ (print)

Parent/Guardian: _____ (signature)

Witness: _____ (signature)

Date effective: _____ Date expired: _____

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Board Certified American Board of Family Medicine

Walk-in-Clinic Hours:
Monday—Friday 9am-8pm
Saturday & Sunday 9am-4pm
www.psfp.net

Member of Puget Sound Family Physicians

Empowering people to lead healthier lives