ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
PHONE: (602) 385-3810

2018-19 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete) Exam Date: _____

Name: _____
Home Address: _____
Phone: _____
Date of Birth: _____
Age: _____
Gender: _____
Grade: _____
School: _____
Sport(s): _____
Personal Physician: _____
Hospital Preference: _____

In case of emergency contact:
Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

		Y	N
1)	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2)	Do you have an ongoing medical conditional (like diabetes or asthma)?	☐	☐
3)	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____	☐	☐
4)	Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): _____	☐	☐
5)	Does your heart race or skip beats during exercise?	☐	☐
6)	Has a doctor ever told you that you have (check all that apply): High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ A Heart Infection ☐		
7)	Have you ever spent the night in a hospital?	☐	☐
8)	Have you ever had surgery?		
9)	Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11)	☐	☐
10)	Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11)	☐	☐
11)	Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below)	☐	☐

☐ Head ☐ Neck ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm
☐ Hand/Fingers ☐ Chest ☐ Upper Back ☐ Lower Back ☐ Hip ☐ Thigh
☐ Knee ☐ Calf/Shin ☐ Ankle ☐ Foot/Toes

	Y	N
12) Have you ever had a stress fracture?	☐	☐
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	☐	☐
14) Do you regularly use a brace or assistive device?	☐	☐
15) Has a doctor told you that you have asthma or allergies?	☐	☐
16) Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
17) Is there anyone in your family who has asthma?	☐	☐
18) Have you ever used an inhaler or taken asthma medication?	☐	☐
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?	☐	☐
20) Have you had infectious mononucleosis (mono) within the last month?	☐	☐
21) Do you have any rashes, pressure sores or other skin problems?	☐	☐
22) Have you had a herpes skin infection?	☐	☐
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	☐	☐
24) Have you ever had a seizure?	☐	☐
26) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	☐	☐
27) While exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
28) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
29) Have you ever been tested for sickle cell trait?	☐	☐
30) Have you had any problems with your eyes or vision?	☐	☐
31) Do you wear glasses or contact lenses?	☐	☐
32) Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
33) Are you happy with your weight?	☐	☐
34) Are you trying to gain or lose weight?	☐	☐
35) Has anyone recommended you change your weight or eating habits?	☐	☐
36) Do you limit or carefully control what you eat?	☐	☐
37) Do you have any concerns that you would like to discuss with a doctor?	☐	☐

Females Only

	Y	N
38) Have you ever had a menstrual period?	☐	☐
39) How old were you when you had your first menstrual period?	_____	
40) How many periods have you had in the last year?	_____	

Explain "Yes" Answers Here

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2018-19 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: _____ Date of Birth: _____

Patient History Questions: Please Tell Me About Your Child...

		Y	N
1)	Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	☐	☐
2)	Has your child ever had extreme shortness of breath during exercise?	☐	☐
3)	Has your child had extreme fatigue associated with exercise (different from other children)?	☐	☐
4)	Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	☐	☐
5)	Has a doctor ever ordered a test for your child's heart?	☐	☐
6)	Has your child ever been diagnosed with an unexplained seizure disorder?	☐	☐
7)	Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	☐	☐

Family History Questions: Please Tell Me About Any Of The Following In Your Family...

		Y	N
8)	Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowing or near drowning)	☐	☐
9)	Are there any family members who died suddenly of "heart problems" before age 50?	☐	☐
10)	Are there any family members who have unexplained fainting or seizures?	☐	☐
11)	Are there any relatives with certain conditions, such as:	☐	☐

	Y	N		Y	N
Enlarged Heart	☐	☐	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	☐	☐
Hypertrophic Cardiomyopathy (HCM)	☐	☐	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	☐	☐
Dilated Cardiomyopathy (DCM)	☐	☐	Marfan Syndrome (Aortic Rupture)	☐	☐
Heart Rhythm Problems	☐	☐	Heart Attack, Age 50 or Younger	☐	☐
Long QT Syndrome (LQTS)	☐	☐	Pacemaker or Implanted Defibrillator	☐	☐
Short QT Syndrome	☐	☐	Deaf at Birth	☐	☐
Brugada Syndrome	☐	☐			

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

_____ _____ _____
Signature of Athlete Signature of Parent/Guardian Date

_____ _____
Signature of MD/DO/ND/NMD/NP/PA-C/CCSP Date

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2018-19 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name: _____ Date of Birth: _____
Age: _____ Sex: _____
Height: _____ Weight: _____
% Body Fat (optional): _____ Pulse: _____
BP: ____ / ____ (____ / ____, ____ / ____)
Vision: R20/____ L20/____ Corrected: Y ☐ N ☐
Pupils: Equal ☐ Unequal ☐

	Normal	Abnormal Findings	Initials *
Medical			
Appearance			
Eyes/Ears/Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary &			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hands/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

* - Multi-examiner set-up only
& - Having a third party present is recommended for the genitourinary examination

NOTES:

☐ Cleared Without Restriction
☐ Not Cleared For: ☐ All Sports ☐ Certain Sports: _____ Reason: _____
Recommendations: _____

Name of Physician (Print/Type): _____ Exam Date: _____
Address: _____ Phone: _____
Signature of Physician: _____, MD/DO/ND/NMD/NP/PA-C/CCSP

 NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.

Arizona Interscholastic Association, Inc.

Mild Traumatic Brain Injury (MTBI) / Concussion

Annual Statement and Acknowledgement Form

I, _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (http://www.cdc.gov/concussion/HeadsUp/youth.html) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:

Print Name: _____ Signature: _____

Date: _____

Parent or legal guardian must print and sign name below and indicate date signed.

Print Name: _____ Signature: _____

Date: _____

HIGH SCHOOL UNIFIED SPORTS PARTICIPANT RELEASE

RELEASE FORM MUST BE COMPLETED BY PARENT/GUARDIAN OF STUDENT IN ORDER TO PARTICIPATE IN HIGH SCHOOL UNIFIED SPORTS AT AN AIA MEMBER HIGH SCHOOL.

THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED, AND DATED TO BE CONSIDERED VALID

PARTICIPANT NAME **First** _____ **Last** _____

D.O.B. _____/_____/_____ **School** _____

GENERAL RELEASE: TO BE COMPLETED BY ALL HIGH SCHOOL UNIFIED SPORTS PARTICIPANTS

I am the Parent or Guardian of the high school Unified Sports participant named above and agree to the following:

1. **Able to Participate.** The participant is physically able to take part in Special Olympics / AIA Unified Sports.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") and the Arizona Interscholastic Association to use the participant's likeness, photo, video, name, voice, and words to promote Special Olympics / AIA Unified Sports and raise funds for Special Olympics / AIA Unified Sports.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to participate with or after a concussion or other injury. The participant may have to get medical care if there is a suspected concussion or other injury. The participant also may have to wait 7 days or more and get permission from a doctor before playing sports again.
4. **Emergency Care.** If a parent or guardian is unavailable to consent or make medical decisions in an emergency, I authorize Special Olympics and/or the Arizona Interscholastic Association to seek medical care for the participant, unless one of the following boxes is checked:
   - ☐ I have a religious or other objection to receiving medical treatment.
   - ☐ I do not consent to blood transfusions.

   (If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, the participant may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If the participant takes part in a Special Olympics health program, I consent to health activities, exams, and treatment for the participant. This should not replace regular health care. I can say no to treatment or anything else any time for the participant.
7. **Personal Information.** I understand my information may be used and shared by Special Olympics and/or the Arizona Interscholastic Association to:
   - Make sure I am eligible and can participate safely;
   - Run trainings and events and share results;
   - Put my information in a computer system;
   - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
   - Research, share, and respond to needs of Special Olympics athletes (identifying information removed if shared publically); and
   - Protect health and safety, respond to government requests, and report information required by law.

   I can ask to see and change my information.

As the parent or guardian of the high school Unified Sports participant, I have read and understand this form and have explained the contents to the participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the participant.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

ADDITIONAL UNIFIED PARTNER RELEASE: TO BE COMPLETED BY GENERAL EDUCATION STUDENTS ONLY

Waiver and Liability Release. I understand the risks involved with participation in Special Olympics / AIA Unified Sports activities. I fully accept and assume all such risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. I hereby release and covenant not to sue any Special Olympics organization and/or the Arizona Interscholastic Association, its administrators, directors, agents, volunteers, and employees, and other participants ("Releasees") related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I have read this waiver and release and understand that I have given up substantial rights by signing it. I have signed it freely and without any inducement or assurance and intend it be a complete and unconditional release of all liability to the greatest extend allowed by law. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.

I, the Parent/Guardian of this Unified Partner participant, acknowledge that I have read and understand the additional provisions stated above. By signing below, I agree to these provisions on my own behalf and on behalf of the Unified Partner participant.

Parent/Guardian Signature _____ Date: _____