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

2024-25 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

NextCare URGENT CARE
EXCLUSIVE URGENT CARE PARTNER OF THE AIA

(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: _____
Sex Assigned at Birth: _____
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) List past and current medical conditions: _____		
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 stinging 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 had surgery? (Please list): _____	☐	☐
8) 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 10)	☐	☐
9) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 10):	☐	☐
10) 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
11) Have you ever had a stress fracture?	☐	☐
12) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	☐	☐
13) Do you regularly use a brace or assistive device?	☐	☐
14) Has a doctor told you that you have asthma or allergies?	☐	☐
15) Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
16) Have you ever used an inhaler or taken asthma medication?	☐	☐
17) Do you have groin or testicular pain, or a painful bulge or hernia in the groin area?	☐	☐
18) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ?	☐	☐
19) Have you had infectious mononucleosis (mono) within the last month?	☐	☐
20) Do you have any rashes, pressure sores or other skin problems?	☐	☐
21) Have you had a herpes skin infection?	☐	☐
22) 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")?	☐	☐
23) Have you ever had a seizure?	☐	☐
24) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	☐	☐
25) While exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
26) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
27) Have you ever been tested for sickle cell trait?	☐	☐
28) Are you happy with your weight?	☐	☐
29) Are you trying to gain or lose weight?	☐	☐
30) Has anyone recommended you change your weight or eating habits?	☐	☐
31) Do you limit or carefully control what you eat?	☐	☐
32) Do you have any concerns that you would like to discuss with a doctor?	☐	☐

Females Only

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

Explain "Yes" Answers Here

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

Student Name: _____ Date of Birth: _____

Patient History Questions: Please Share 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?	☐	☐

Explain "Yes" Answers Here

COVID-19

		Y	N
1)	Was your child hospitalized as a result for complications of COVID-19?	☐	☐
2)	Has your child had any long-term complications from COVID-19?	☐	☐
3)	Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist) to be cleared to return to sports?	☐	☐

Explain "Yes" Answers Here

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last two weeks, how often have you been bothered by any of the following problems? (circle responses)

	Not At All	Several Days	Over Half The Days	Nearly Every Day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

If you score a sum of 3 or greater on either questions 1 and 2, or 3 and 4, you may have anxiety or depression that is affecting you more than normal. In this case, it is recommended that you talk to a trusted health care provider such as your primary care physician, your athletic trainer at school, or a counselor at school. If there is not someone you feel comfortable talking to or you are interested in learning more to help yourself or a friend, please use the resources provided below.

For more information regarding student-athlete mental health:
Quiet Suffering - A Resource for Student-Athlete Mental Health
spark.adobe.com/page/lLtwyoLpTAp0V/

Teen Lifeline Call and Text Crisis Line
(602) 248-8336 (TEEN)
Outside Maricopa county call: 1-800-248-8336 (TEEN)
Hours are: Call 24/7/365 | Text weekdays 12-9 p.m. & weekends 3-9 p.m. | Peer counseling 3-9 p.m. daily
Crisis text line: Text HOME to 741741 to connect with a crisis counselor

National Suicide Prevention Lifeline
988 or suicidepreventionlifeline.org

The Trevor Lifeline
866-488-7386 (for gender diverse youth)

Family History Questions: Please Share About Any Of The Following In Your Family

	Y	N
1) Are there any family members who had sudden/unexpected/unexplained death before age 35? (including SIDS, car accidents drowning or near drowning)	☐	☐
2) Are there any family members who died suddenly of "heart problems" before age 35?	☐	☐
3) Are there any family members who have unexplained fainting or seizures?	☐	☐
4) 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 35 or Younger	☐	☐
Long QT Syndrome (LQTS)	☐	☐	Pacemaker or Implanted Defibrillator	☐	☐
Short QT Syndrome	☐	☐	Deaf at Birth	☐	☐
Brugada Syndrome	☐	☐			

Explain "Yes" Answers Here

Additional History

	Y	N
1) Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?	☐	☐
2) Do you drink alcohol or use illicit drugs?	☐	☐
3) Have you ever taken anabolic steroids or used any other performance-enhancing supplements?	☐	☐
4) Have you ever taken any supplements to help you gain or lose weight, or improve your performance?	☐	☐
5) Do you always wear a seatbelt while in a vehicle?	☐	☐

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 Student-Athlete | Signature of Parent/Guardian | Date

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

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2024-25 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 ☐
Cleared With Following Restriction: _____
Not Cleared For: ☐ All Sports ☐ Certain Sports: _____ Reason: _____
Medically eligible for all sports without restriction with recommentations for further evaluation or treatment of:

_____

Recommendations: _____

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

AIA ARIZONA INTERSCHOLASTIC ASSOCIATION™

OUR STUDENTS, OUR TEAMS . . . OUR FUTURE.

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: _____

2024-25 CONSENT TO TREAT FORM

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the Arizona Interscholastic Association (AIA), _____ (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/AIA, to the extent the QMP deems necessary to prevent harm to the student-athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant or nurse practitioner licensed by the state of Arizona (or the state in which the student-athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by Arizona law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designate

PLEASE PRINT LEGIBLY OR TYPE

"I, _____, the undersigned, am the parent/legal guardian of, _____,

a minor and student-athlete at _____
(name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by Arizona law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/AIA.

Date: _____ Signature: _____

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 Olympicsaccredited 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 concussionor other injury. The participant may have to get medical care if there is a suspected concussion or other injury. The participant also may haveto 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 Olympicsand/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 forthe 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 InterscholasticAssociation 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: _____

OFFICIAL SPECIAL OLYMPICS CONSENT FORM

Athlete Name: First_____**Last**_____

D.O.B.: ____/___/_____

RELEASE TO BE COMPLETED BY PARENT/GUARDIAN OR ADULT ATHLETE (OWN GUARDIAN)

THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED, AND DATED TO BE CONSIDERED VALID FOR THREE (3) YEARS

I, the Parent/Guardian or Adult Athlete submits this Official Special Olympics Release Form for participation in Special Olympics.

Section 1

I represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics activities. I also represent that a licensed medical examiner (MD/DO/NP/PA-C) has reviewed the health information contained in the application for participation and has certified, based on a medical examination, that there is no medical evidence which would preclude the athlete from participating in Special Olympics.

Section 2

I understand that if the athlete has Down syndrome, the athlete cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine unless the athlete and medical examiner have completed the official "Down syndrome Addendum Form", available from the Special Olympics State Office. I am aware that the x-ray exam is required before any athlete with Down syndrome may participate in equestrian, gymnastics, judo, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and soccer.

Section 3

Special Olympics has my permission, both during and any time after, to use the athlete's likeness, name, voice or words in either television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

Section 4

If during the athlete's participation in Special Olympics activities, the athlete should need emergency medical treatment, and I (the parent/guardian or adult athlete) am not able to give consent or make arrangements for that treatment, I authorize Special Olympics to take whatever measures necessary to protect the athlete's health and well-being, including if necessary, hospitalization.

Section 5

I understand by signing below, that I consent to participate in the **Special Olympics Healthy Athletes Program** that provides individuals screening assessments of health status and health care needs in the areas of vision, oral health, hearing, physical therapy, and a variety of health promotion areas. I understand there is no obligation for the athlete to participate in the Healthy Athletes Program and that the athlete may decide not to participate. Provisions of these health services are not intended as a substitute for regular care. I also understand that I should seek independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not responsible for the health of the athlete. I understand that information gathered as part of the screening process may be used anonymously to assess and communicate overall health and needs of athletes and to develop programs to address those needs.

Section 6

I understand the nature and risk of concussion and head injuries, including the risks of continuing to play after concussion or head injury. I acknowledge that Special Olympics has a concussion awareness and safety recognition policy that may require an athlete to seek medical attention from a medical professional in the event of a suspected concussion. Any athlete suspected of sustaining a concussion will not be permitted to return to Special Olympics sports activities until written medical clearance is provided and at least 7 days have passed since the date of the suspected injury. I further acknowledge that additional information regarding concussions may be found on the Centers for Disease Control Heads Up website at http://www.cdc.gov/headsup/youthsports/index.html.

To be completed by Adult Athlete (own Guardian)

I, the adult athlete, have read this form and fully understand the provisions of the release that I am signing. I acknowledge that I have read and agree to the Athlete Code of Conduct and the Code of Conduct Compliance Policy. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Signature _____

Print Name _____

Date: ____/____/____

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its terms.

Signature _____

Print Name _____

OR

To be completed by Parent/Guardian

I, the Parent/Guardian of this athlete, hereby give my permission for this athlete to participate in Special Olympics games, training, recreation programs, physical activity programs and Healthy Athletes program. I acknowledge I have read and agree to the Athlete Code of Conduct and the Code of Conduct Compliance Policy. By signing, I am saying that I agree to the provisions of this release.

Signature _____

Print Name _____

Date: ____/____/____