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

2021-22 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?	☐	☐

Explain "Yes" Answers Here

COVID-19...

	Y	N
1) Has your child been diagnosed with COVID-19?	☐	☐
1a) If yes, is your child still having symptoms from their COVID-19 infection?	☐	☐
2) Was your child hospitalized as a result for complications of COVID-19?	☐	☐
3) Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)?	☐	☐
4) 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?	☐	☐
5) Has your child returned back to full participation in sports?	☐	☐
6) Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?	☐	☐
6a) Was your child tested for COVID-19?	☐	☐
7) Did your child receive the COVID-19 vaccine?	☐	☐

7a) What was the manufacturer of the vaccine? _____

7b) Date of vaccination(s) _____

Explain "Yes" Answers Here

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

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

		Y	N
1)	Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowning or near drowning)	☐	☐
2)	Are there any family members who died suddenly of "heart problems" before age 50?	☐	☐
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 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 Student-Athlete | Signature of Parent/Guardian | Date

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

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

2021-22 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: _____
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: _____

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

2021-22 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 designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

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: _____