

**SAFFORD UNIFIED SCHOOL DISTRICT**

**Athletic Clearance Information**

**2015-2016**

These forms are for all students attending Safford Middle School or Safford High School to participate in interscholastic athletics. You will need to have the following items on file:

- ❖ Athletic Clearance Information
  - Emergency Information
  - Acknowledgment of Athletic Department rules and by-laws
  - Consent for Emergency Care/Medical Consent/Release Forms
  - Health Insurance Information
  - SUSD Random Drug and Alcohol Testing Consent
- ❖ Preparticipation Physical Evaluation (AIA Form 15.7A & 15.7B)
- ❖ AIA MTBI/Concussion Acknowledgement Form (AIA Form 15.7C)
- ❖ AIA Concussion Education Class Brainbook (one time only)
- ❖ Baseline neurocognitive assessment (concussion testing for contact sports)
- ❖ Pay participation fee prior to the start of sport

Student's Full Name: \_\_\_\_\_ Grade (2015-16): \_\_\_\_\_

Gender (please circle):    Male    Female            Age: \_\_\_\_\_            Date of Birth: \_\_\_\_\_

Did you attend Safford High School or Safford Middle School last year?    YES    NO

If No, name of school last attended: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

*If you are a transfer student, please see the athletic director as soon as possible.*

Please list the sports you plan to participate in for the 2015-2016 school year.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**EMERGENCY INFORMATION**

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Father/Guardian Name: \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Be sure to read the forms carefully, double check and make certain the forms are filled out completely and signed by the parent and the student. Incomplete forms and/or illegible responses will result in student's ineligibility. Parents: It is rare that we lose or misplace these forms; you may want to keep a copy for your records. Return all forms when completed to Safford High School main office, Attn: Athletic Trainer.

**SAFFORD UNIFIED SCHOOL DISTRICT ATHLETIC DEPARTMENT**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF COMPANY: \_\_\_\_\_  
 COMPANY ADDRESS: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 COMPANY PHONE: \_\_\_\_\_  
 POLICY/ ID # \_\_\_\_\_ Plan: \_\_\_\_\_  
 POLICY HOLDER'S NAME: \_\_\_\_\_

**Emergency Contacts**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

**Medical Conditions:** Please list any medical information concerning the above named student athlete, including current medications.

\_\_\_\_\_

\_\_\_\_\_

**Allergies:** Please list any allergies of the above named student athlete.

\_\_\_\_\_

\_\_\_\_\_

**ATHLETIC DEPARTMENT BY-LAWS Acknowledgment Statement**

Athletic department by-laws can be found on the SHS athletic department website under downloads. We have reviewed, understand, and agree to abide by the Athletic Department By-Laws.

**BASELINE CONCUSSION TESTING**

Safford High is taking a proactive approach in managing the cognitive function of our student athletes by partnering with Axon Sports and using its Computerized Cognitive Assessment Tool (CCAT) as part of a concussion management program. The purpose of the Axon Sports CCAT is to establish and store a Baseline of cognitive function. In the event your child sustains a suspected concussion or other traumatic brain injury (TBI), the baseline results can be compared with your child's performance on an After Injury test. This comparison helps to indicate any change in cognition and is an important tool in the overall concussion management program. We ask that you take a few minutes to review important documents on axonsports.com where you will also find important information about the company and the CCAT. By granting consent, you certify that you reviewed the Axon Sports Terms of Use and Privacy Policy. I hereby grant consent to the registration of my child on axonsports.com and to the administration and supervision of the CCAT test by SHS and hereby accept the terms of use and privacy policy on behalf of myself and my child.

**MANDATORY INFORMED CONSENT**

We give our son/daughter permission to participate in interscholastic athletics. We realize such activity involves potential for injury, which is inherent in all sports and activities. We understand there is a meeting where specific risks will be presented. We understand that if we have questions pertaining to this risk, we will address them to the coach, athletic director, or athletic trainer. We realize that even with the best coaching, use of the most advanced protective equipment, and strict observance of rules, injuries are still a possibility. We understand that these injuries range from minor to severe; on rare occasions, the injuries may be so severe as to result in total disability, paralysis, quadriplegia, or even death. We understand and acknowledge these risks. We understand the specific risks associated with the sport or activities in which my child will participate, and we have read and understand this warning. We also understand we can contact school medical personnel if there are any changes to my child's health, if pertinent information needs to be communicated for appropriate medical care, or if there are any limitations to my child's activities. We accept the risks as a condition of my child's participation in sports and activities.

**CONSENT FOR MEDICAL CARE**

I, the undersigned parent/guardian of the student named above, hereby give and grant unto any medical doctor, hospital, or athletic trainer my consent and authorization to render aid, treatment or care to said student as, in judgment of doctor, medical personnel, or hospital that may be required, on an emergency basis, in the event said student should be ill or stricken ill while participating in or traveling to or from an interscholastic activity sponsored by or sanctioned by the Arizona Interscholastic Association, Inc. of which Safford Schools is a member. It is hereby understood that the consent and authorization hereby given and granted is continuing, and are intended by me to extend throughout the current school year. We, hereby, give consent for the designated school personnel, athletic trainer, or coach to issue first aid, and use his/her judgment in activating the emergency medical system, and we hereby grant permission for the athletic trainer to treat my son/daughter.

**AUTHORIZATION/CONSENT TO RELEASE PRIVILEGED HEALTHCARE INFORMATION**

I/We hereby authorize the release of privileged medical/healthcare-related information to the Safford High School athletic training staff as may be needed to provide ongoing care of my child's injuries. I/We also authorize Safford High School athletic training staff to release medically privileged information about my child to other healthcare providers involved with the care and treatment of my child, and to any and all third-party payers in order to secure payment of healthcare-related services.

**CONSENT FOR EMERGENCY CARE**

Be it known that I, the undersigned parent/guardian of the student named above hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment or care to said student as, in judgment of said doctor or hospital may be required, on an emergency basis, in the event said student should be ill or stricken ill while participating in or traveling to or from an interscholastic activity sponsored by or sanctioned by the Arizona Interscholastic Association, Inc. of which Safford Schools is a member. It is hereby understood that the consent and authorization hereby given and granted is continuing, and are intended by me to extend throughout the current school year.

We the undersigned certifies that (1) I have read the foregoing and understand its contents, (2) I am the student-athlete/patient and/or legal representative of the student and authorized to sign on the student's behalf, (3) I received a copy of this document upon request, and (4) I accept all terms contained in this agreement/consent form/waiver/medical records release.

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

## Safford High School Athletic By-Laws

It is the responsibility of each coach to discuss these by-laws with their athletes and parents prior to the start of each season

### Athletic Fees

Athletic fees are due before a student can play in a game. For teams with cut sports, including Volleyball, Boys and Girls Basketball, Boys and Girls Soccer, Spirit Line, Baseball, Softball, Tennis, and Golf, that fee will be due as soon as cuts are made. For teams that do not have cuts, including Football, Cross Country, Wrestling, and Track, that fee will be due two weeks after the start date of the season.

### Athletic Award Criteria

Athletic awards will be given annually upon approval of the Head Coach/Sponsor:

- ① Six inch Varsity Award letter to high school varsity award winner, one per high school career.
- ① Four inch Junior Varsity Award letter to high school Junior Varsity award winner, one per high school career.
- ① 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> year pins symbolic of the sport.
- ① Certificates to all athletes completing a season.
- ① Team Captain(s) emblem for high school varsity team captains.
- ① Baker award to the outstanding senior boy athlete.
- ① Bellamy awards to the outstanding senior girl athlete.
- ① Faunce & Kimball Scholar/Athlete Award to the top male & female scholar/athlete.
- ① Each coach / sponsor is responsible for additional award criteria for their program.

### Athletic Department By-Laws

#### **Code of Conduct**

1. Tobacco, Alcohol and illegal drugs are considered "banned" substances. All "banned" substances will be treated in the same manner.
2. No drinking or possession of alcoholic beverages.
3. No use or possession of tobacco products.
4. No use or possession of illegal drugs or participation in drug trafficking.
5. Character and Citizenship: Students are expected to avoid any act that will bring harm to themselves, parents, community, school or team.

#### **Code Violations**

1. Any violations of parts 1-4 shall be reported to the A.D. in writing and will result in the following consequence(s):
2. First Offense: Out for three weeks of game competition (the days for tryouts/scriimmages do not count).
3. Second Offense: Dismissal from all sports for the remainder of that school year

#### **Defining In-Season Athletes and Administrating of Punishment**

1. A student-athlete is deemed, "In-Season," the day they turn in their signed physical packet, until the last day of that school year even during seasons that they are not actually participating in a sport. Example: Athlete A plays football and only football. Athlete A is considered an "in-season" athlete for the entire school year
2. If a student has not turned in a physical packet with these by-laws signed, they are, "out of season."
3. A student-athlete in violation must sit out three full weeks (21 full days) of competition; if that season ends, the suspension will carry on to the next sport and/or school year(s). Continued Example: If Athlete A commits a violation of the substance abuse code of conduct in February of the current school year, Athlete A will be ineligible for the first three full weeks of competition in the following year's season.
4. A student-athlete serving their suspension must be on the official roster and have their athletic fee paid for that sport in order for them to be a part of that team and for their suspension to count.
5. If a team has a zero tolerance policy for the above, the suspension will not carry over to the next sport/year, as long as there is still three full weeks (21 full days) remaining in that season. Otherwise, the remaining time to be served will carry on.

#### **Conduct and Behavior**

A student athlete will follow the rules and guidelines of their particular activity at all times. Actions or words that are disrespectful to the coaching staff will not be tolerated and could be grounds for dismissal.

#### **Hazing**

All forms of hazing are strictly prohibited. For the purposes of this policy statement, hazing is defined as any act by a single student or group of students to extort something of value, threaten injury, harass, intimidate or cause or attempt to cause physical or emotional injury to any person.

Students who violate this policy will be immediately suspended from the team and will be subject to dismissal or expulsion as per school district policies. This policy is in effect at all times and places year round.

## Attendance: Practice & Games

The following will be followed for all programs in the Safford Athletic Department.

1. In the event that a student has an unexcused absence from practice, that student will be subject to his/her team rules relative to participation in the next contest.
2. Students are expected to attend every class all day in order to practice or participate in a scheduled event.
  - a. All student athletes must be in school on game days. This includes being to school on time, and staying at school the whole day until it is time to be released to go to the bus.
  - b. If you leave school early to go home to pack, go to lunch early, or any other personal reason, you may not be able to play in the game that day.
  - c. If you miss the first hour or two or more of school and come just in time to travel with the team, you may not be able to play in the game that day.
  - d. If you have a doctor's appointment you may leave for that, but please come back with a doctor's note.
3. Exceptions are made for medical excuse and emergencies.

## Due Process for Athletes

In the event that disciplinary action must be taken against any student the following procedures will be followed:

1. The coach has the right and obligation to immediately suspend a student/athlete who violates school or team rules and regulations until the due process procedure has been completed.
2. The coach will inform the athlete of the alleged violation. The athlete will be asked for an explanation.
3. Within five days, the athlete has the right to appeal the coach's decision to the athletic director in writing for further consideration.

## Equipment and Uniforms

1. School uniforms are to be used or worn in competition or practice. Exceptions: A coach may allow certain items of school uniforms to be worn at certain times.
2. Abuse of equipment—"Normal" wear and tear is expected. A student will be held responsible for unusual abuse or loss of equipment.
3. Students will be held responsible for all athletic equipment issued to them.
4. Students shall return all equipment and uniforms issued to them within one week after completion of any season or immediately if dropped from any activity.
5. Students shall pay for all items not returned.

## Student Responsibilities

Participation in school athletics is a privilege that carries with it a certain amount of individual responsibility. The following guidelines are set forth to help each athlete meet and accept those responsibilities.

1. Report all injuries to the coach as soon as possible.
2. Squad members are expected to be punctual in reporting to practice. In case of a necessary absence from practice, the athlete should notify the coach prior to being absent if possible.
3. Athletes should strive at all times, in their dress, actions and behaviors, to reflect only those qualities and characteristics that will bring pride to themselves, their team, and their school.
4. Any athlete who quits a team or is released from a team for any reason may not participate in any other sport until the sport from which he/she dropped has ended. Exceptions are subject to coaches' approval.
5. The school gives athletic awards to those students that successfully participate in the interscholastic athletic program. The minimum requirement for earning an athletic award is completing the season in good standing; however, there may be additional requirements stipulated by the coach.

## Levels of Development

**HS freshmen:** Basic fundamentals are stressed with emphasis on individual and team development. It is recognized that every effort will be made to play all members of the team in all contests.

**HS Junior Varsity:** This level puts more emphasis on team play, conditioning and refinement of basic skills. An attempt will be made to play all participants.

**HS Varsity:** The culmination of the high school athletic experience where playing for a championship is a high priority. Team play, sportsmanship, individual ability, motivation and mental attitudes are very important aspects of competition. Teams definitely play to win, but contestants should accept the fact that important lessons are to be learned from losing. It is recognized that not all participants will play in every game.

**Articulation:** Our varsity team head coaches are expected to direct and provide leadership for all levels of participation. This will help ensure program continuity and consistency.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date



**DRUG USE PREVENTION IN SCHOOL ACTIVITIES**

**(Random Drug and Alcohol Testing)**

**CONSENT FORM**

I understand fully that my performance as a participant and the reputation of my school are dependant, in part, on my conduct as an individual. I acknowledge that I have received and have read a copy of the District's Random Drug and Alcohol Testing policy and regulations. I agree to accept and abide by the standards, policies, rules, and regulation of the District's Random Drug and Alcohol testing policy and regulation.

I request that \_\_\_\_\_ be allowed to participate in the school-sponsored extracurricular activity subject to the District's Random Drug and Alcohol testing policy and regulations. I agree that the above-mentioned student be subject to the District's Random Drug and Alcohol Testing program for the duration of the activity.

I accept the methods of the collection process, testing procedures, and sample analysis, and all other aspects of the District's Random Drug and Alcohol testing program. I authorize the District to conduct a test on a urine and/or saliva specimen which I provide on-site for test for alcohol and drug use if my name is drawn from a random pool. I agree that to remain eligible to participate in a school-sponsored extracurricular activity the above-mentioned student is subject to retesting during the duration of the activity.

I further agree and consent to the disclosure of the sampling, testing, and results provided for this program. This consent is given pursuant to all state and federal privacy statutes, and is a waiver of rights to nondisclosure of such test records and results only to the extent of the disclosures in the program.

Pursuant to the District's Random Drug and Alcohol Testing policy and regulations, I also authorize the release of information concerning the results of such test to designated District personnel.

The parent must sign this request if the student is under eighteen (18) years of age. *Only the student needs to sign if eighteen (18) years of age or over.*

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

I have decided not to allow, \_\_\_\_\_, to participate in any school-sponsored extracurricular activity by the District for the remainder of this school year.

I understand that participation in the school-sponsored extracurricular activity at a later date will require submission to the District's Random Drug and Alcohol Testing policy and regulations.

The parent must sign this request if the student is under eighteen (18) years of age. *Only the student needs to sign if eighteen (18) years of age or over.*

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date



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: \_\_\_\_\_



## 2015-2016 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Exam Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Sex: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Grade: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Sport(s): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Personal Physician: \_\_\_\_\_  
 Hospital Preference: \_\_\_\_\_

In case of emergency, contact:  
 Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_  
 (Work): \_\_\_\_\_  
 (Cell): \_\_\_\_\_

---

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_  
 (Work): \_\_\_\_\_  
 (Cell): \_\_\_\_\_

Explain "Yes" answers on 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?	<input type="checkbox"/>	<input type="checkbox"/>			
2) Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>			
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>			
4) Do you have allergies to medicines, pollens, foods, or stinging insects? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>			
5) Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
6) Has a doctor ever told you that you have (check all that apply): High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7) Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>			
8) Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>			
* 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, circle affected area in the box below):	<input type="checkbox"/>	<input type="checkbox"/>			
* 10) Have you had any broken/fractured bones or dislocated joints? (If yes, circle affected area in the box below):	<input type="checkbox"/>	<input type="checkbox"/>			
* 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, circle affected area in the box below):	<input type="checkbox"/>	<input type="checkbox"/>			
Head <input type="checkbox"/>	Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/>	Upper Arm <input type="checkbox"/>	Elbow <input type="checkbox"/>	Forearm <input type="checkbox"/>
Hand/Fingers <input type="checkbox"/>	Chest <input type="checkbox"/>	Upper Back <input type="checkbox"/>	Low Back <input type="checkbox"/>	Hip <input type="checkbox"/>	Thigh <input type="checkbox"/>
	Knee <input type="checkbox"/>	Calf/Shin <input type="checkbox"/>	Ankle <input type="checkbox"/>	Foot/Toes <input type="checkbox"/>	

	Y	N
12) Have you ever had a stress fracture?		
13) Have you 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 medicine?		
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?		
25) Do you have headaches with exercise?		
26) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?		
27) When 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?	<input type="checkbox"/>	<input type="checkbox"/>
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**





## 2015-2016 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(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?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>

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, drowning, or near drowning)	<input type="checkbox"/>	<input type="checkbox"/>
9) Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
10) Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
11) Are there any relatives with certain conditions, such as:		
Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm problems:		
Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>
Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack, age 50 or younger	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Deaf at Birth (Congenital Deafness)	<input type="checkbox"/>	<input type="checkbox"/>

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: \_\_\_\_\_



**2015-2016 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*
<b>Medical</b>			
Appearance			
Eyes/Ears/ Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary †			
Skin			
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/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