

The Preferred Urgent Care of the Arizona **Interscholastic Association**

2018-2019 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Parent or Guardian should fill out this form with assistance from the student athlete.) Exam Date: In case of emergency, contact: Name: Name: Home Address: Phone: Relationship: Date of Birth: Phone (Home): Age: (Work): Sex: (Cell): Grade: School: Name: Sport(s): Relationship: Personal Physician: Phone (Home): **Hospital Preference:** (Work): Explain "Yes" answers on following page. (Cell): Circle questions you don't know the answers to. Y Ν 1) Has a doctor ever denied or restricted your participation in sports for any reason? 2) Do you have an ongoing medical condition (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 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 spent the night in the 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, circle affected area in the box below): *10) Have you had any broken/fractured bones or dislocated joints? (If yes, circle affected area in the box below): * 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 **Upper Back** Chest diH Lower Back Thigh Knee Calf/Shin Ankle Foot/Toes

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	Y		N	1
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?]	Ĺ	
17) Is there anyone in your family who has asthma?]	L	
18) Have you ever used an inhaler or taken asthma medicine?]	L	4
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?] _	L	
20) Have you had infectious mononucleosis (mono) within the last month?]	L	_
21) Do you have any rashes, pressure sores, or other skin problems?		<u> </u>	L	
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")?] -	L	
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?			L	
30) Have you had any problems with your eyes or vision?]		
31) Do you wear glasses or contact lenses?]	L	
32) Do you wear protective eyewear, such as goggles or a face shield?]	L	
33) Are you happy with your weight?]	L	
34) Are you trying to gain or lose weight?]	L	
35) Has anyone recommended you change your weight or eating habits?]		
36) Do you limit or carefully control what you eat?	L]		
37) Do you have any concerns that you would like to discuss with a doctor?	L		L	
Females Only Explain "Yes" Answers Here			_	_
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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?				



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Student Name:	Date of Birth:		
atient History Questions: Please tell me about you			
	V A		
Has your child fainted or passed out DURING or AFTER exercise, emotic	on or startle?		
2) Has your child ever had extreme shortness of breath during exercise?			
Has your child had extreme fatigue associated with exercise (different to the content of th	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?	ining exercise:		
Has your child ever been diagnosed with an unexplained seizure disor.	dor?		
7) Has your child ever been diagnosed with exercise-induced asthma not			
7) Has your Clind ever been diagnosed with exercise-induced astilina not	well controlled with medication:		
8) Are there any family members who had sudden, unexpected, unexplain	ned death before age 50? (including SIDS, car accidents, drowning, 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 seiz	ures?		
11) Are there any relatives with certain conditions, such as:			
	Y N Marfan Syndrome (Aortic Rupture)		
Enlarged Heart	Heart Attack, age 50 or younger		
Hypertrophic Cardiomyopathy (HCM)	Pacemaker or Implanted Defibrillator		
Dilated Cardiomyopathy (DCM)	Deaf at Birth (Congenital Deafness)		
Heart Rhythm problems:			
Long QT Syndrome (LQTS)	Explain "Yes" Answers Here		
Short QT Syndrome			
Brugada Syndrome			
Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)			
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)			
hereby state that, to the best of my knowledge, my answer bove questions are complete and correct. Furthermore, I ac nd understand that my eligibility may be revoked if I have r outhful and accurate information in response to the above o	knowledge not given		
Signature of athlete Signature of pa	rent/guardian Date		
Signature of MD/DO/ND/NMD/NP/PA-C/CCSP	Date:		



2018-2019 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name:		Date of Birth:	
Age:		Sex:	
Height:		Weight:	
% Body fat (optional):		Pulse:	
,		BP:/(/)	
Vision: R20/	120/		
	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/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			
† Having a		mended for the genitourinary examination.	
NOTES:			
	Sports Certain Sports	☐ Reason:	
Name of Physician(Print/Typ	e):	Exam Date:	
Address:		Phone:	
Signature of Physician:		, MD/DO/ND/NMD/NP/PA-C/CCSP	



Arizona Interscholastic Association, Inc.

Mild Traumatic Brain Injury (MTBI) / Concussion

Annual Statement and Acknowledgement Form

I, (student), acknowl	edge that I have to be an active participant in my own health
and have the direct responsibility for reporting all of	f my injuries and illnesses to the school staff (e.g., coaches,
team physicians, athletic training staff). I further re-	cognize that my physical condition is dependent upon
providing an accurate medical history and a full disc	losure of any symptoms, complaints, prior injuries and/or
disabilities experienced before, during or after athle	tic 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 a	nd sign name below and indicate date signed.
Print Name:	Signature:
Date:	