Student Athletic Participation Papers

Parent/Guardian The following attached forms must be completed for the 2022-23 school year if your student is going to participate in any extracurricular activity. The forms must be completed and returned to the High School office. New students must provide a copy of their birth certificate. **Arizona Interscholastic Association (AIA) policy requires all student athletes must have a physical examination by a certified doctor each school year.** If a student transfers from another school and has taken a physical, a copy of that physical must be provided. These forms and the copy of the birth certificate are kept on file in the High School office. Copies of some forms are given to coaches as needed. These forms enable coaches/advisors in providing medical help, if needed. **Students are not allowed to begin participation/practice without these forms on file.** Following is an explanation of the attached forms.

Participation and Travel Form

The upper portion of this form gives the student the right to travel for sports trips and your signature states that you are aware of a possible injury. The lower portion is your health insurance information. **Each participant is required to have proof of insurance.** This is required by AIA. Family insurance, state funded health insurance for uninsured youth (age 18 and below) or student accident and health insurance are acceptable. If your family does not have access to insurance, the school has access to insurance at a low cost with different plans to choose from to cover your student. Please contact the school.

Annual Pre-participation Physical Evaluation & Examination

These forms need to be submitted to your doctor when your student goes for his/her physical. Once reviewed by the Athletic Director, this form will be put on file in the High School office. **Please have your doctor use the provided forms.** They must be AIA forms.

"Over the Counter" Permission Slip

This form will provide the school with a list of "over the counter" drugs that can be administered to the student/athlete if the need arises. **No School Representative is allowed to give any OTC pain medication (such as Tylenol or Motrin).**

Student Athlete Rules

This is a summary of the Athletic Policies that your student will be required to follow. You, and your student, must sign each form in order for your student to participate. These include: Illegal Substance Policy, Random Drug Testing Policy, Eligibility Policy, Practice Requirements, School Attendance Policy, Hazing Policy, FMUSD Drug and Alcohol Prevention Policy, and the Acknowledgment & Consent to Test form.

Student Activity Fee

Any student participating in an extracurricular activity must pay $35 (thirty-five dollars) per activity. This will be used to cover the cost of athletic activities. This form has been provided to allow you to check which activities your student will participate in. **All fees must be paid prior to participation in the activity, no exceptions.** You can either pay the total fees for extracurricular activities all at once or at the beginning of each activity throughout the school year. If you prepay for the activity and the student is unable to begin participation in that activity, a refund will be made. If the student begins participation (including practice) in the activity, no refund will be made.

Participation and Travel Form

I give permission for __________________________________ to participate in organized high school athletics and to travel to all out of town activities, realizing that such activities involve the potential for injury which is inherent in all sports. I acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis or even death. I acknowledge that I have read and understand this warning.

I also understand by signing below that I am granting permission for any School District employee to act in my stead, should an emergency or accident occur to my child while in their care, including, but not limited to, seeking medical attention for my child. Medical facilities and those under their employ have my permission to act in the best interest of my child at the request of any School District employee.

____________________________________ ________________
Parent/Guardian Signature Date

____________________________________ ________________
Student/Participant Signature Date

Insurance Form

The school does not participate in AIA Insurance coverage for AIA sponsored activities. The AIA Insurance does not pay if the parent already has insurance coverage. Parents who do not have insurance coverage must enroll in one for their student. If you are interested in purchasing Student Accident and Health Insurance, the application can be picked up in the High School office. **Insurance coverage or an insurance waiver must be filed with the High School office before the athlete will be allowed to practice or participate in any of the activities.**

WAIVER OF ATHLETIC AND ACTIVITY INSURANCE

I, parent/guardian of__________________________________ do understand that by signing this waiver of AIA Insurance, all claims will be paid through my group health insurance according to their schedule of benefits. By my signature I hereby release the Fredonia–Moccasin Unified School District #6 of any accident liability incurred by my child.

Paren/Guardian Name: ____

Home Phone: ________________________ **Cell Phone:** ____________________

Name of Insurance Company: ____
Insurance/Group #::__________________________ ID #:__________________________
Policy/Issuer #: ____

____________________________________ ________________
Parent/Guardian Signature Date

Over The Counter – Permission Slip

I hereby give permission for my student, ______________________________ to receive the following medication from the coach of the particular sport he/she is participating in or the school designee, as necessary.

_________________________________ ________________

Parent/Guardian Signature Date

______	Heat Pack	______	Hydrogen Peroxide
______	Cold Pack	______	PhisoDerm
______	Athletic Foot Spray	______	First Aid Cream
______	Skin Toughener	______	Isopropyl Alcohol
______	Antiseptic Spray	______	Spray/Liquid Bandage
______	Foot Powder	______	Caladryl
______	Grid Aid	______	Burn Spray
______	Liniment	______	Merthiolate
______	Eye Drops	______	Ammonium Capsule
______	Foot Ointment/Antibiotic	______	Rosin Mixture
______	Half/Half (Analgesic Balm & Red Hot)	______	Skin Lubricant/Antiseptic
______	Strawberry Ointment	______	Rub Down Ointment
______	Epsom Salts	______	Nitiotein (Skin Ointment)
______	Mouthwash	______	Sun Glare

Student Athlete Rules

Illegal Substances

Any student participating in school sponsored activities is prohibited to be under the influence, or participate in the use, of any drug or alcohol during any school function, activity, event, practice, class, or season of sport, or while on school property or in school vehicles. For the purposes of this policy, the term "drug" shall include and refer to: alcohol, controlled substances, illicit and illegal drugs, performance-enhancing drugs, nicotine, all other substances deemed illegal or harmful. Random drug screening will be used by the school to detect substance abuse. However, this is not the only form of evidence used by the school in determining violations. Violations will follow the *Drug and Alcohol Prevention and Education Program Policy* outline.

Random Drug Testing

Please read and sign the attached *Drug and Alcohol Prevention and Education Program Policy* and Testing Consent form.

Eligibility

The progress report or term grade is the basis for eligibility. Students are eligible if they are passing all of their classes. If a student has a progress report grade of "F" they will be given a Deficiency Notice on Monday afternoon and a copy will be mailed home. The student then has one (1) week to bring that grade up to a passing grade with no consequence. The student is eligible to participate during this one-week grace period. The deadline for bringing grades up shall be the first day of the following week at 4:30pm. It is the student's responsibility to collect, complete and turn in all necessary make-up work. The student must deliver a teacher signed Deficiency Notice to the Athletic Director, or Principal, by the deadline. After the deadline the Athletic Director will notify coaches of any ineligible players. All participants who did not bring their grades up to a passing grade will be ineligible. This ineligibility will continue on a weekly basis until a passing grade is achieved. If a term grade of "F", or a term GPA of less than 2.0 is issued, there is no grace period. That student is ineligible until the first progress report of the following term. If a student received a "No Credit" notification, he/she is ineligible until a petition for credit has been completed and the terms of the petition have been fulfilled.

Practices

A high school athlete shall have a minimum of then (10) practices before entering into any interscholastic competition. The purposes of such practices are:

- To provide adequate conditioning to the athlete.
- To provide necessary skills to be taught prior to competition to prevent injury
- To prevent any unnecessary legal problems.

This requirement may be waived by the Athletic Director or Principal for students participating in consecutive sports. No student shall practice until the physical evaluation is turned in.

School Attendance

Student athletes are expected to attend class. This is especially true on the day of an activity. A student is required to attend all classes on the day of an activity. If travel to an activity requires students to miss class time, the school will excuse them, as it deems necessary. If a student does not attend all classes on the day of an activity, they are not eligible to participate that day. A student too sick to attend school is too sick to practice or participate in a game. Parents are encouraged not to schedule appointments for their students on the day of an activity. Excused absences for a death in the family, medical or dental appointments, or religious observances should be approved in advance by school administration. These approved absences will not

affect eligibility. Students who miss at least one period of any school day without being excused are considered "truant." If a student athlete is found to be truant they will be ineligible for the next activity. For this purpose an activity is defined as the next Varsity game and any JV games previous to the Varsity game.

Hazing

Any student involved in the initiation or hazing of another student will be disciplined by the High School Principal. Discipline may include a period of ineligibility or removal from the team.

I, the undersigned, hereby acknowledge and agree that I have read and understand the FHS Student Athlete Rules as provided with this form and that I will fully comply with the Rules during the term of my participation in covered activities. I further understand and acknowledge that participation in any of the School's covered activities and programs is a privilege and not a right, and that my ability to participate is contingent upon following the FHS Student Athlete Rules.

Signature:

____ ____________

Student/Athlete **Date**

I, the undersigned, hereby acknowledge and agree that I have read and understand the FHS Student Athlete Rules as provided with this form and that my student will fully comply with the Rules during the term of his/her participation in covered activities. I further understand and acknowledge that participation in any of the School's covered activities and programs is a privilege and not a right, and that his/her ability to participate is contingent upon following the FHS Student Athlete Rules.

Signature:

____ ____________

Parent/Guardian **Date**

FMUSD Drug and Alcohol Prevention and Education Program Policy

NOTE: *This is an excerpt from the policy. A copy of the entire policy is available from the High School Office.*

For the education, safety, and welfare of the students and to promote a drug-free school environment, the District adopts the following drug and alcohol prevention and education program. It is the goal of the District to keep students from using drugs and to help those who may already be drug dependent. The purpose is not strictly disciplinary, but is intended to provide help and support to teacher, administrators, counselors, students, and their families. It is also intended to improve the overall academic, physical, and social education programs of the District. We believe that by identifying substance abuse, we will improve the safety, health, and general well being of students and staff members.

Any student participating in school sponsored activities is prohibited to be under the influence, or participate in the use, of any drug or alcohol during any school function, activity, event, practice, class, or season of sport, or while on school property or in school vehicles. For the purposes of this policy, the term "drug" shall include and refer to: alcohol, controlled substances, illicit and illegal drugs, performance-enhancing drugs, nicotine, all other substances deemed illegal or harmful.

Consent to testing is a condition of practice for and participation in any school sponsored activities. All students are subject to periodic unannounced drug and alcohol testing on a random selection basis. Once tested, all student names will be returned to the pool group and have an equal chance of being selected during each random selection process. Each student shall be eligible for random testing throughout the participation season(s) for his/her activity(s).

Positive test results and all other findings will be reported to the student and his or her parent(s) or guardian(s) on the same day that verified results are received by the District. Negative test results will not be reported.

A violation of this policy, even a first offense, will serve as the basis for discipline. Any student who violates this policy will be subject to the following consequences. Violations carry over year-to-year and activity-to-activity. There is no "fresh start" each year or each activity. A student's violation record will be cumulative throughout his/her high school career. All suspension periods will commence with the Parent Conference informing them of a positive result. All consequences must be fully satisfied in order to re-establish eligibility for participation in activities.

First Occurrence

A. The student will be referred to a substance abuse professional for a substance abuse evaluation. He/She must comply with whatever recommendations are made by the counselor, including any additional treatments and/or programs. Any costs associated with analysis, counseling, treatment, and programs will be the sole responsibility of the student and his/her parent(s) or guardian(s).

B. The student may be subject to additional on-campus counseling and/or substance abuse education provided by the District.

C. The student will be subject to periodic, unannounced drug/alcohol testing throughout the remainder of the participation season for his/her activity. The student may also be automatically selected for each remaining random testing batch throughout his/her school career.

D. The student will be suspended from full participation in any covered activity for a period of 30 calendar days. The student will not be allowed to participate in any practices, rehearsals, or meetings relating to

his/her activity until the substance abuse evaluation in Consequence A has been completed. After the evaluation has been completed the student may practice/rehearse, but may not compete/perform in any competitions/performances for the remainder of the 30-day suspension period. The student will be returned to full participation on the 31st consecutive calendar day following suspension, provided that all other eligibility requirement are met.

Second Occurrence

A. As outlined under "First Occurrence."

B. As outlined under "First Occurrence."

C. As outlined under "First Occurrence."

D. As outlined under "First Occurrence" with the exception that the suspension shall be 45 calendar days.

Third and Subsequent Occurrences

A. As outlined under "First Occurrence."

B. As outlined under "First Occurrence."

C. As outlined under "First Occurrence."

D. As outlined under "First Occurrence" with the exception that the student will be suspended from participating in any covered activity for one (1) calendar year.

Self-Referral

Students may report, in writing, to administration that he/she has an identified, current substance abuse problem and is seeking treatment. In the event that such a self-report is received before the student is selected for testing the student will be considered for reduced consequences. The student's parent(s)/guardian(s) will be notified of his/her referral. Once a student has tested positive, the self-referral is no longer an option. The student will face the same consequences as a first occurrence positive test, with the exception that the suspension shall be 10 calendar days.

Due Process

Students and parents or guardians will be notified, in writing, of all conditions regarding suspension. Student and parent(s)/guardian(s) have the right to appeal to the school principal, in writing, within 15 days of any decision. An appeal of the school's decision will be directed to the Governing Board of Fredonia-Moccasin Unified School District. The Governing Board may choose to hear, or may choose not hear the appeal.

Acknowledgment & Consent to Test Form

I, the undersigned, hereby acknowledge and agree that I have read and understand the FMUSD's Drug and Alcohol Prevention and Education Program Policy as provided with this form and that I will fully comply with the said Policy during the term of my participation in covered activities.

I also understand that I will be tested for chemical substance (drug/alcohol) abuse. I hereby consent to such testing and authorize the release of information concerning the results of such tests to designated District personnel. I understand that I may be randomly and/or periodically tested throughout the designated time of my participation in covered activities.

I fully release and discharge the District and its subsidiaries, affiliates, predecessors, assigns and their officers, directors, employees, agents and attorneys, from any and all liabilities and claims now known or unknown, arising out of my participation in the programs referred to above or any actions which the District has taken or may take in connection therewith; and I will indemnify, defend and hold harmless the District from and against any and all actions, suits, proceedings, judgments and orders, and the costs of defense and settlement thereof (including reasonable attorney's fees) arising out of my participation in such programs or any actions of the District.

I further understand and acknowledge that participation in any of the District's covered activities and programs is a privilege and not a right, and that my ability to participate is contingent upon my ability to successfully pass a drug and/or alcohol test, and that testing will be administered periodically throughout the season of participation in extracurricular activities. Furthermore, should this screening produce a confirmed and verified positive test result, I will be subject to discipline and assistance as outlined in the District's Alcohol and Drug Free Program Policy.

Acknowledged and Agreed to:

____
Student/Athlete Name (print)

____ __________
Student/Athlete Signature **Date**

____
Parent/Guardian Name (print)

____ __________
Parent/Guardian Signature **Date**

______________________________ ______________________________
Parent/Guardian Home Phone Number **Parent/Guardian Work Phone Number**

____
Parent/Guardian Cell Phone Number

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

2023-24 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: ____________
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

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

	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 non-functioning 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) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	☐	☐
26) While exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
28) Have you ever been tested for sickle cell trait?	☐	☐
29) Have you had any problems with your eyes or vision?	☐	☐
30) Do you wear glasses or contact lenses?	☐	☐
31) Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
32) Are you happy with your weight?	☐	☐
33) Are you trying to gain or lose weight?	☐	☐
34) Has anyone recommended you change your weight or eating habits?	☐	☐
35) Do you limit or carefully control what you eat?	☐	☐
36) 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

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

2023-24
ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

NextCare URGENT CARE
EXCLUSIVE URGENT CARE PARTNER OF THE AIA

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

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

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
1-800-273-8255 or suicidepreventionlifeline.org

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

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:		

Condition	Y	N	Condition	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 ____________

AIA

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

2023-24 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

NextCare URGENT CARE

EXCLUSIVE URGENT CARE PARTNER OF THE AIA

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

FORM 15.7-B 02/22/2023 (rev.) NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.

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: __________

FORM 15.7-C 06/2015

2023-24 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: ______________________________________