



2018-2019 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/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/NP/PA-C



2018-2019 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

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

Exam Date: _____

Name: _____
 Home Address: _____
 Phone: _____
 Date of Birth: _____
 Age: _____
 Sex: _____
 Grade: _____
 School: _____
 Sport(s): _____
 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 A Heart Murmur High Cholesterol A Heart Infection	<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, check 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"/>	Lower 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"/>	

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(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:



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: _____