AIA ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 North 18th Stree t, Phoenix, Arizona 85020-5552
Phone: (602) 385-3810



# 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? | ☐ | ☐ |
| 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 ☐ Chest ☐ Upper Back ☐ Lower Back ☐ Hip ☐ Thigh ☐
Knee ☐ Calf/Shin ☐ Ankle ☐ Foot/Toes ☐

| | 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? | | |
| 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

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# 2018-2019 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? | ☐ | ☐ |
| 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? | ☐ | ☐ |

## 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) | ☐ | ☐ |
| 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 seizures? | ☐ | ☐ |
| 11) Are there any relatives with certain conditions, such as: | ☐ | ☐ |

| | Y | N |
|---|---|---|
| Enlarged Heart | ☐ | ☐ |
| Hypertrophic Cardiomyopathy (HCM) | ☐ | ☐ |
| Dilated Cardiomyopathy (DCM) | ☐ | ☐ |
| Heart Rhythm problems: | ☐ | ☐ |
| Long QT Syndrome (LQTS) | ☐ | ☐ |
| Short QT Syndrome | ☐ | ☐ |
| Brugada Syndrome | ☐ | ☐ |
| Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) | ☐ | ☐ |
| Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) | ☐ | ☐ |
| Marfan Syndrome (Aortic Rupture) | ☐ | ☐ |
| Heart Attack, age 50 or younger | ☐ | ☐ |
| Pacemaker or Implanted Defibrillator | ☐ | ☐ |
| Deaf at Birth (Congenital Deafness) | ☐ | ☐ |

## 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: _____

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# 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/ND/NMD/NP/PA-C/CCSP

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