Attached is the 2017-2018 AIA sports Annual Preparticipation Physical Evaluation and Examination. You may use this form to obtain your child's sports physical and doctor's clearance. Sports packets will be available after April 1st and may be turned in after July 1st.

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

2017-2018 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?	☐	☐
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, circle affected area in the box below):	☐	☐

Head ☐ Neck ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm ☐
Hand/Fingers ☐ Chest ☐ Upper Back ☐ Low Back ☐ Hip ☐ Thigh ☐
Knee ☐ Calf/Shin ☐ Ankle ☐ Foot/Toes ☐

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2017-2018 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:	☐	☐
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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2017-2018 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

FORM 15.7-B 03/12 NextCare is the preferred partner of the AIA, it is not required you visit NextCare locations for your healthcare needs.