

For Office Use Only

Student Name: \_\_\_\_\_

Student Perm ID: \_\_\_\_\_

Date Received: \_\_\_\_\_

Concussion Test Score/Date: \_\_\_\_\_

Date Cleared: \_\_\_\_\_ Initials \_\_\_\_\_

# **RIO RICO HIGH SCHOOL ATHLETICS**

“Home of the HAWKS”



## **Athletic Participation Packet**

**THIS PACKET MUST BE COMPLETED BY  
ALL ATHLETES ON A YEARLY BASIS**

- ✓ Parent Permission and Proof of Insurance Form
- ✓ Concussion Statement & Acknowledgement Form
- ✓ Release of Liability/Informed Consent/Assumption of Risk Waiver
- ✓ Annual Pre-Participation Physical Evaluation (Parent)
- ✓ Annual Pre-Participation Physical Examination (Physician)
- ✓ Athletic fee due **prior** to participation

All information must be completed before athlete will be cleared for participation in their particular sport. Insurance is required; insurance may be purchased from the Myers-Stevens & Toohy Company, Inc. for a nominal cost.

### **CONCUSSION TEST**

Concussion test must be completed and passed with an 80% or better before athlete can participate in any sport. The test must only be taken and passed one time. The following website address is where you take the test.

Go to: <http://www.aiaacademy.org/>

Click: “Concussion Education Brainbook”

Click: Register as Student

**Please Return Completed Packets To:**

**Arlette Salgado- Athletic Secretary**

asalgado@scv35.org (520) 375-8781



# RIO RICO HIGH SCHOOL ATHLETICS

## “Home of the HAWKS”

### Parent Permission/Emergency Consent/Proof of Insurance

“I/WE 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, quadriplegia or even death.” (Arizona Interscholastic Association)

I/WE, the parents or legal guardians of \_\_\_\_\_ hereby give our consent for him/her to engage in interscholastic athletics during the 2017-2018 School Year.

\_\_\_\_\_ I/WE understand that the school district has no financial responsibility if accidents occur to students while taking part in athletics.

Initial

\_\_\_\_\_ I/WE certify that our son/daughter is fully covered with \_\_\_\_\_ medical/health insurance company.

Initial

Name of Insurance Company

\_\_\_\_\_ I/WE permit emergency medical care to be administered to our son/daughter in the event it is required, as deemed necessary by the Rio Rico High School Coach, Administrator, or Athletic Trainer during any athletic-related activities.

Initial

\_\_\_\_\_ I/WE understand that certain emergencies require immediate transportation to a hospital.

Initial

\_\_\_\_\_ I/WE will allow the involved hospital and/or doctor to administer the required treatment for this condition.

Initial

I/WE have read and understand the training rules relating to the athletic department and understand the penalties that may be imposed for failure to comply with standard expected of athletes who represent Rio Rico High School.

\_\_\_\_\_  
Father's Signature

\_\_\_\_\_  
Mother's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Home Phone

IN AN EMERGENCY, IF PARENTS CANNOT BE CONTACTED PLEASE NOTIFY THE FOLLOWING:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

INSURANCE: (The student **MUST SHOW** proof of insurance to participate. RRHS does offer insurance through the Myer-Stevens & Toohey Company). It is the parents/guardians responsibility to purchase and contact the insurance company directly.

Name of Insurance \_\_\_\_\_

Insurance Policy Number \_\_\_\_\_

**Santa Cruz Valley Unified School District No. 35**  
**School-Sponsored Extracurricular Pre-Season/Post Season**  
**Athletic Activities.**

**RELEASE OF LIABILITY/INFORMED CONSENT/ASSUMPTION OF RISK WAIVER**

\_\_\_\_\_ (Student's Name) desires to participate  
in \_\_\_\_\_ (Name of Program) sponsored by the Santa Cruz Valley Unified School District No. 35.

The Santa Cruz Valley Unified School District No. 35, coaches and activity sponsors and all others involved in the administration of this program have pledged to utilize every reasonable precaution to minimize or eliminate the potential for injury by students as a result of athletic participation. Being fully informed as to these risks and in consideration for being allowed to participate in this activity, I hereby assume all risk of injury, damage and liability arising from participation in this activity. I have read this Release of Liability and Assumption of Risk Agreement. In addition, I understand and agree to follow all Santa Cruz Valley Unified School District No. 35 Governing Board Policies and Procedures.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Your Name Here: \_\_\_\_\_ Grade: \_\_\_\_\_

\*\*\*\*\*

I certify that I am the parent/legal guardian of the above-named student; that I have read and understand this Release of Liability and Assumption of Risk Agreement. I certify that I have explained the risks and dangers to my child. I hereby release and hold harmless the Santa Cruz Valley Unified School District No. 35., its Partners in Education, coaches, volunteers, medical personnel, security officers, administrative officials, other employees, volunteers and agents from any liability, actions, causes of action, claims, judgments cost or expense, including attorney fees, known or unknown at this time, arising out of or in any way related to any injury or illness incurred by my child while participating in, or travelling to and from any practice, game, or special event. I have voluntarily chosen to allow my child to participate and assume all such dangers and risks. I request that my son/daughter be permitted to participate in extracurricular athletic activities sponsored by the Santa Cruz Valley Unified School District No. 35.

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_ Telephone: Work: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Is this student covered by a medical insurance policy? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, provide the name of your insurance company and policy number:

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Emergency Contact Information:**

If I cannot be contacted and a reasonable effort has been made to do so, I authorize the coaching staff or the Principal and his or her designee to act on my behalf. I further authorize my son/daughter to be transferred and admitted to any hospital or medical facility for diagnosis and treatment if deemed necessary. I request and authorize any duly licensed Doctors of Medicine, Doctors of Dentistry or other such licensed technicians or nurses to perform any diagnostic, treatment or operative procedures including x-ray diagnosis of my child. I assume the responsibility for the payment of any such transfer and treatment.

Preferred Hospital: \_\_\_\_\_

Person to be contacted if I am not available: \_\_\_\_\_

Telephone: Work: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_



**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: \_\_\_\_\_



## 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?	<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 <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection <input type="checkbox"/>	<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, circle 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"/> Low 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"/>		

	<b>Y</b>	<b>N</b>
12) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
13) Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
15) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
16) Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17) Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
18) Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
20) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
21) Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
22) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
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")?	<input type="checkbox"/>	<input type="checkbox"/>
24) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
25) Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
26) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>
27) When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
28) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
29) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
30) Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
31) Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
32) Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
33) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
34) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
35) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
36) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
37) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

Females Only

Explain "Yes" Answers Here

	<b>Y</b>	<b>N</b>
38) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
39) How old were you when you had your first menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
40) How many periods have you had in the last year?	<input type="checkbox"/>	<input type="checkbox"/>



## 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?	<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:	<input type="checkbox"/>	<input type="checkbox"/>
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: \_\_\_\_\_



## 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*
<b>Medical</b>			
Appearance			
Eyes/Ears/ Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary †			
Skin			
<b>Musculoskeletal</b>			
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: \_\_\_\_\_

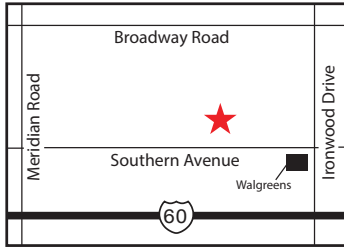
Recommendations: \_\_\_\_\_

Name of Physician(Print/Type): \_\_\_\_\_ Exam Date: \_\_\_\_\_

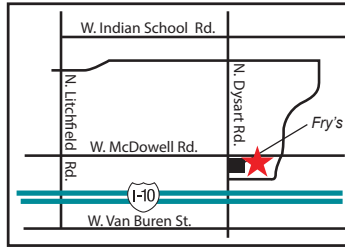
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_, MD/DO/ND/NMD/NP/PA-C/CCSP

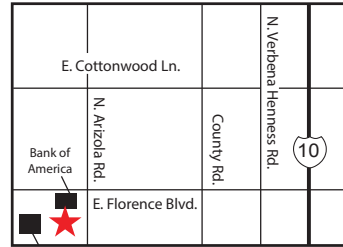




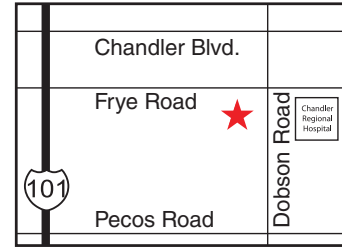
**Apache Junction • 85120**  
 2080 West Southern Ave., Suite #A1



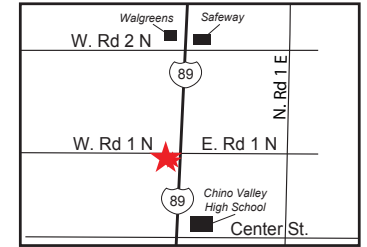
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 13075 W. McDowell Rd., Suite #D106



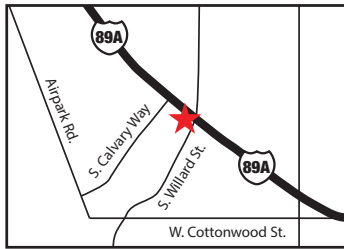
**Casa Grande • 85122**  
 1683 E. Florence Blvd., Suite #7



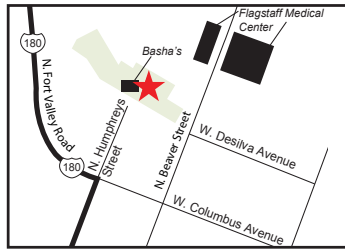
**Chandler • 85224**  
 600 S. Dobson Road, Suite #C-26



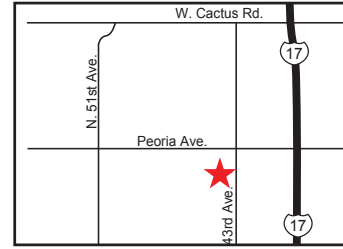
**Chino Valley • 86323**  
 474 State Highway 89



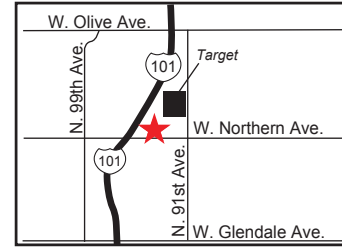
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 450 S. Willard Street, Suite #120



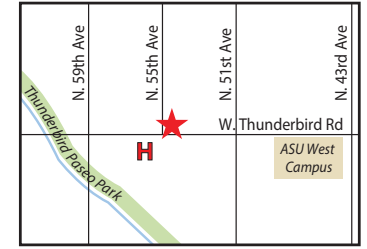
**Flagstaff • 86001**  
 1000 N. Humphreys St., Suite #104



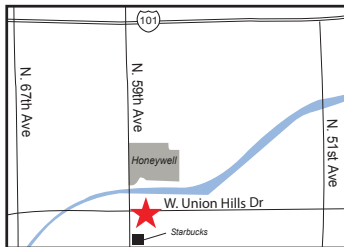
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 10240 N. 43rd Ave., Suite #3



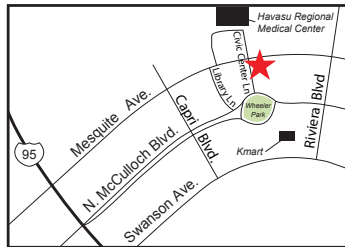
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 9494 W. Northern Ave., Suite #101



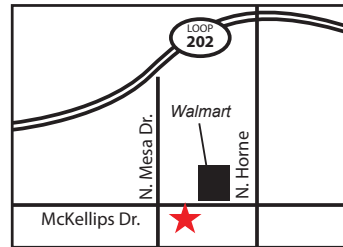
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 5410 W. Thunderbird Road, Suite #101



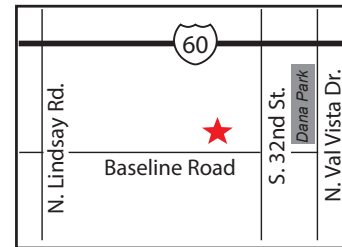
**Glendale • 85308**  
 18589 N. 59th Ave., Suite #101



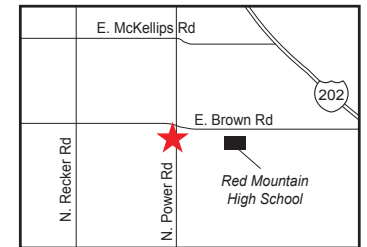
**Lake Havasu City • 86403**  
 1810 Mesquite Ave., Suite B



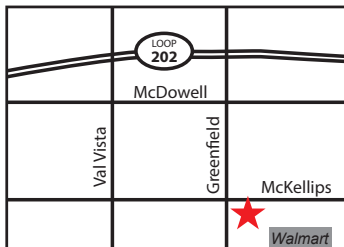
**Mesa • 85203**  
 535 E. McKellips Road, Suite #101



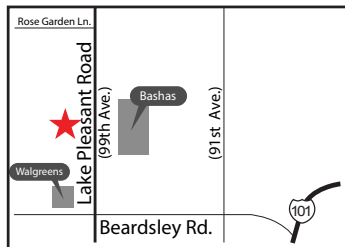
**Mesa • 85204**  
 3130 E. Baseline Road, Suite #105



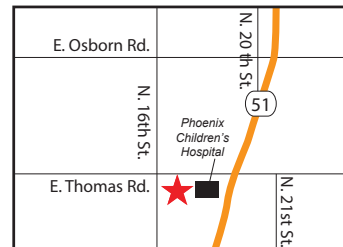
**Mesa • 85205**  
 1066 N. Power Road, Suite #101



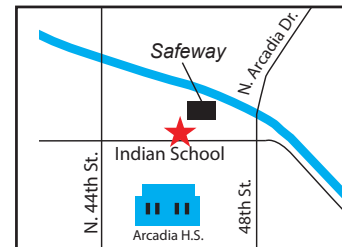
**Mesa • 85215**  
 4401 E. McKellips Road, Suite #102



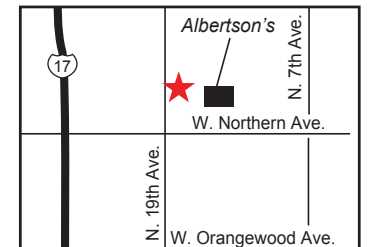
**Peoria • 85382**  
 20470 N. Lake Pleasant Rd., Suite #102



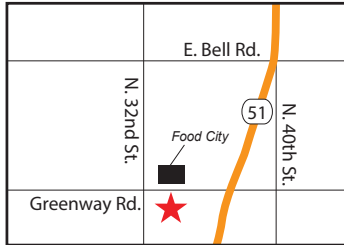
**Phoenix • 85016**  
 1701 E. Thomas Road, Suite #A104



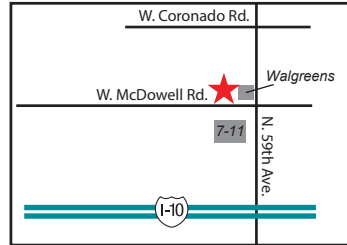
**Phoenix • 85018**  
 4730 E. Indian School Rd., Suite #211



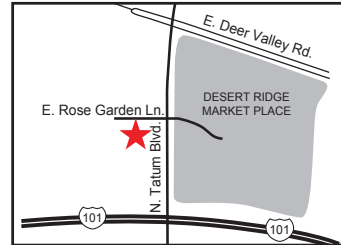
**Phoenix • 85021**  
 8101 N. 19th Ave., Suite #A



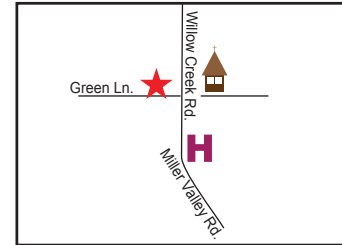
**Phoenix • 85032**  
 3229 E. Greenway Rd., Suite #102



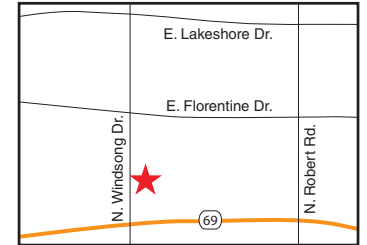
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 5920 W. McDowell Road



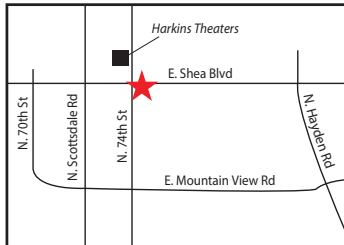
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 20950 N. Tatum Blvd., Suite #190



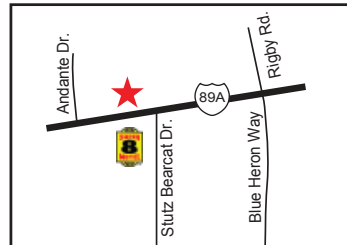
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 2062 Willow Creek Road



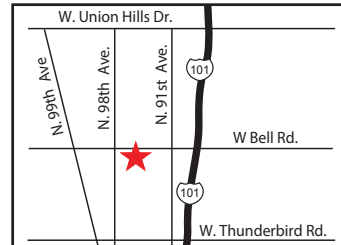
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 3051 N. Windsong Drive



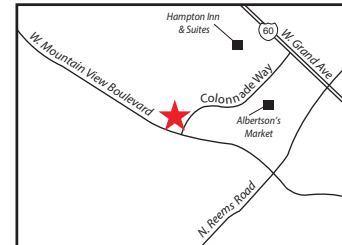
**Scottsdale • 85260**  
 7425 E. Shea Blvd., Suite #108



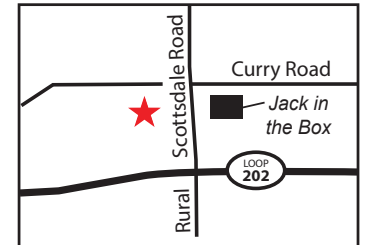
**Sedona • 86336**  
 2530 W. SR 89A, Suite #A



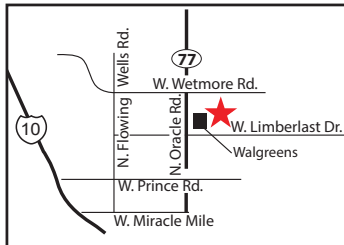
**Sun City • 85351**  
 9745 W. Bell Road, Suite #105



**Surprise • 85374**  
 14800 W. Mtn. View Blvd., Suite #100



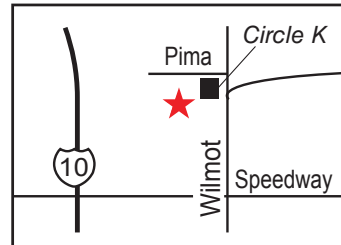
**Tempe • 85281**  
 914 N. Scottsdale Rd., Suite #104



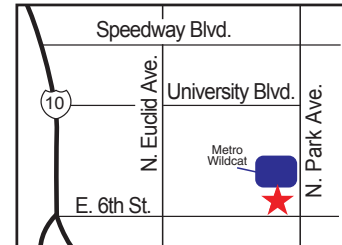
**Tucson • 85705**  
 4280 North Oracle Rd., Suite #100



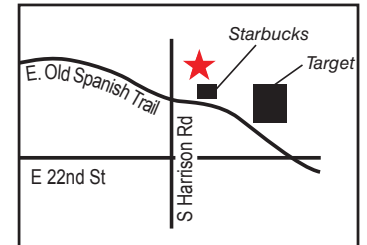
**Tucson • 85706**  
 5369 S. Calle Santa Cruz, Suite #145



**Tucson • 85712**  
 6238 E. Pima Street



**Tucson • 85719**  
 501 North Park Ave., Suite #110



**Tucson • 85748**  
 9525 E. Old Spanish Trail, Suite #101