AIA ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
PHONE: (602) 385-3810

2019-20 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: _____
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

	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 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?	☐	☐
26) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	☐	☐
27) While 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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2019-20 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

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 drowing 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		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 Athlete _____ Signature of Parent/Guardian _____ Date _____

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP _____ Date _____

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team osteopathic physicals for students

Upcoming School Name_____

First Name_____ Last Name_____

CARDIOVASCULAR

Family History Yes- No _____

Personal History Yes-No_____

EKG_____

ECHO NEEDED_____ ECHO DONE_____ NORMAL_____ ABNORMAL_____

ECHO FINDINGS_____

*I understand and give permission for my child to have a free sports screening with an EKG and ECHO (if necessary). This information may be used for medical research (no names would be mentioned).

*I hereby authorize TOPS (Team of Physicians for Students) to publish the photographs/videos taken of me or my child, and my/his/her name, for use in the TOPS' printed publications and website.
I acknowledge that since my participation in publications and websites produced by TOPS is voluntary, I will receive no financial compensation.
I further agree that my participation in any publication and website produced by TOPS confers upon me no rights of ownership whatsoever. I release TOPS, its contractors and its employees from liability for any claims by me or any third party in connection with my participation.

Signature of Parent/Guardian/ Student if over 18_____