AIA ARIZONA INTERSCHOLASTIC ASSOCIATION
OUR STUDENTS, OUR TEAMS . . . OUR FUTURE.
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
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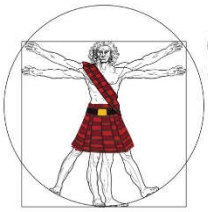

Scott Medical SOLUTIONS
118 W. 5th St, Safford, AZ 85546
Ph: (928) 348-7100

ANNUAL PREPARTICIPTAION PHYSICAL EVALUATION

School Year:_____ **Exam Date:** _____

Part 1 - Demographics				
To be completed by parent or guardian.				
Student Name:				**Emergency Contacts**
Physical Address:				**Name:**
City:	**State:**	**Zip:**		**Relationship:**
Phone:				**Phone (Cell):**
Date of Birth:	**Age:**			**Phone (Work):**
Gender:	**Grade**			**Name:**
School:				**Relationship:**
Sport(s)				**Phone (Cell):**
Physician:	**Phone:**			**Phone (Work):**

Part 2 – Medical Questionnaire					
Check "Yes" or "No". Explain "Yes" answers on the bottom of page 2				**YES**	**NO**
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 over-the-counter medications 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 any of the following? (Check all that apply) High Blood Pressure ☐ Heart Murmurs ☐ 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, tendonitis, etc.) that caused you to miss a game or practice? (If yes, check affected area in the box below question 11)					
10. Have you ever had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below 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	☐ Face	☐ Mouth

Part 2 – History (Continued)		
Check "Yes" or "No"	YES	NO
12. Have you ever had a stress fracture?		
13. Have you ever been told that you have, or have 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 missing, or 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. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?		
26. While exercising in the heat, do you have sever muscle cramps or become ill?		
27. Has a doctor told you that you or someone in your family has sickle cell trait or disease?		
28. Have you ever been tested for sickle cell trait?		
29. Have you had any problems with your eyes or vision?		
30. Do you wear glasses or contact lenses?		
31. Do you wear protective eyewear, such as goggles or a face shield?		
32. Are you happy with your weight?		
33. Are you trying to gain or lose weight?		
34. Has anyone recommended you change your weight or eating habits?		
35. Do you limit or carefully control what you eat?		
36. Do you have any concerns that you would like to discuss with a doctor?		

Females Only		
Check "Yes" or "No", or fill answer	YES	NO
37. Have you ever had a menstrual period?		
38. How old were you when you had your first menstrual period? _____		
39. How many periods have you had in the last year? _____		

Explain "Yes" Answers Here

Section 3 – Personal Medical History	
To be filled out by healthcare provider with the assistance from the parent or guardian.	
Student Name:	**Date of Birth:**

Patient History Questions. Check "Yes" or "No"	YES	NO
1. Has your child fainted or passed out DURING or AFTER exercise, when emotional, or startled?		
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 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?		

Section 4 – Family History		
To be filled out by healthcare provider with the assistance from the parent or guardian.	YES	NO
8. Are there any family members who had sudden/unexpected/unexplained death before age 50? (included 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:

	YES	NO		YES	NO
a. Enlarged Heart			h. Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)		
b. Hypertrophic Cardiomyopathy (HCM)			i. Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)		
c. Dilated Cardiomyopathy (DCM)			j. Marfan Syndrome (Aortic Rupture)		
d. Heart Rhythm Problems			k. Heart Attack, Age 50 or Younger		
e. Long QT Syndrome (LQTS)			l. Pacemaker or Implanted Defibrillator		
f. Short QT Syndrome			m. Deaf at Birth		
g. 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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Section 5 – Physical Examination	
To be completed by the healthcare provider.	
Name:	**Date of Birth:**
Age:	**Sex:**
Height:	**Weight:**
BMI:	**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/Hands/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			

*** - Multi-examiner set-up only / & - Having a third party present recommended**

Notes:

☐ **Cleared Without Restriction**

☐**Not Cleared For:** ☐**All Sports** ☐**Certain Sports: _____ Reason:_____**

Recommendations:_____

Name of Provider (Print/Type): _____ Exam Date: _____

Address: _____ Phone:_____

Signature of Provider: _____, MD/DO/ND/NMD/NP/PA-C/CCSP

FORM 15.7-A 02/2014 REVISED