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



# 2020-21 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? | ☐ | ☐ |
| 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 severe muscle cramps or become ill? | ☐ | ☐ |
| 27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell 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

| | Y | N |
|---|---|---|
| 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

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# 2020-21 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