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 ☐

	Y	N
12) Have you ever had a stress fracture?		
13) Have you 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 medicine?		
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) Do you have headaches with exercise?		
26) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?		
27) When 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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(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: