



# SECOND MESA DAY SCHOOL

"ITAH TSATSAYOM MOPEKYA"

Paulesha Sewemaenewa, *Board President*  
Sherry Lomayestewa, *Board Member*  
VACANT, *Board Member*  
VACANT, *Board Member*  
Jasmine Dashee, *Board Member*  
Kimberly K. Thomas, *School Principal*

May 29, 2024

Dear Parents/Guardians:

**WELCOME AND THANK YOU** for selecting Second Mesa Day School, "**HOME OF THE MIGHTY BOBCATS**", as your choice to educate your children. This is a responsibility that Second Mesa Day School and Staff take seriously, and we look forward to having your children attend our school.

Attached is the enrollment packet for School Year 2024-2025. The check-off list is to use as a guide for completing your child's enrollment registration. All items listed on the check-off list must be completed and signed with all required documents submitted for your child's enrollment to be considered complete.

## **STUDENTS ENTERING KINDERGARTEN**

Students entering Kindergarten, must be 5 years of age on or before September 1, 2024. A decision will be authorized by the Principal/CSA for age requirements on a case-by-case basis IF child's birthdate is before December 31, 2024. Final determination will be based on child's maturity and educational readiness for Kindergarten level. Parents and/or guardians will be consulted by Principal/CSA and Kindergarten Teacher with a decision.

We encourage all parents/guardians and families to be engaged in your children's academic, athletic, and social needs to meet their desires. We look forward to working with you and your children for another great and wonderful school year! ***ASQUALI - "Itah Tsatsayom Mopekya"***

Sincerely,

A handwritten signature in black ink that reads "Kimberly Thomas". The signature is fluid and cursive.

Kimberly Thomas, Principal/CSA  
Second Mesa Day School



**SECOND MESA DAY SCHOOL**  
 P.O. Box 98  
 Second Mesa, Arizona 86043  
 (928) 737-2571 / Fax (928) 737-2565



**New Student Registration  
 Checklist**

**SCHOOL YEAR 2024-2025**

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

***Check List of Required documents/forms, to be officially registered.***

***(PLEASE MAKE SURE ALL FORMS ARE SIGNED BY PARENT AND/OR GUARDIAN WHERE NECESSARY.)***

- |                                                   |                                                               |
|---------------------------------------------------|---------------------------------------------------------------|
| _____ Student Enrollment Application              | _____ Technology – Student Usage Agreement                    |
| _____ Parental Consent Form                       | _____ Internet Acceptable Use Policy                          |
| _____ Student Check-Out / Bus Transportation Form | _____ Physical Examination Form                               |
| _____ Medical Attention Form                      | _____ Withdrawal Records                                      |
| _____ Student Health History-Part I & II          |                                                               |
| _____ Library Permission Form                     |                                                               |
| _____ Release of Student Records                  |                                                               |
| _____ HHCC Dental Screening Form                  | _____ Birth Certificate ( <b><u>Mandatory</u></b> )           |
| _____ HHCC Influenza Vaccination Form             | _____ Tribal Enrollment/CIB ( <b><u>Mandatory</u></b> )       |
| _____ Over-The-Counter Medication Consent         | _____ Guardian Affidavit – if applicable (1 page)             |
| _____ Home Language Survey Form                   | _____ Updated Immunization Record ( <b><u>Mandatory</u></b> ) |
| _____ McKinney-Vento Form                         |                                                               |

***\*\* These items are mandatory at time of enrollment. Student will not start school until all documents are received.***

This Section For Office Use Only

RECEIVED BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
 COMPLETE \_\_\_\_\_ PENDING \_\_\_\_\_ NOTE: \_\_\_\_\_

CSA/PRINCIPAL SIGNATURE: \_\_\_\_\_

APPROVED DATE: \_\_\_\_\_  DISAPPROVED DATE: \_\_\_\_\_

Entry Date: \_\_\_\_\_ Enrollment Code: \_\_\_\_\_ Enrollment #: \_\_\_\_\_

Teacher Placement: \_\_\_\_\_ Grade: \_\_\_\_\_



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**2024-2025**

**NEW STUDENT REGISTRATION**

**PART 1**

**Student Identification:**

Grade Applying \_\_\_\_\_

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

Male  Female  DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Student Ethnicity (Choose one of the following Federally Mandated Categories)

- |                                                                            |                                                                    |
|----------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> American Indian or Alaskan Native<br>Tribe: _____ | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian                                             | <input type="checkbox"/> Black or African American                 |
| <input type="checkbox"/> Caucasian or White                                | <input type="checkbox"/> Other _____                               |

**PART 2**

Student's Home Physical Address: **(Please explain in detail the physical location of your home and draw map of your home location on the back of this form or attach google map)**

\_\_\_\_\_

Student's Mailing Address (PO Box #/City/Zip Code) \_\_\_\_\_

Community/Village Student resides in: \_\_\_\_\_

Student's Dominant Language Spoken at home: 1. \_\_\_\_\_ 2. \_\_\_\_\_

**PART 3 - FAMILY DATA INFORMATION**

**With whom does student live with:** *(If other than father / mother, please provide guardianship documentation)*

- Mother     Father     Both Parents     Grandparents     Guardian - Other (Specify) \_\_\_\_\_

**PRIMARY PARENT OR LEGAL GUARDIAN INFORMATION** *(With whom student lives with)*

**(PARENT/GUARDIAN 1)**

**(PARENT/GUARDIAN 2)**

NAME: \_\_\_\_\_ NAME: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home#: \_\_\_\_\_ Home#: \_\_\_\_\_

Cell#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Work#: \_\_\_\_\_ Work#: \_\_\_\_\_

Message # : \_\_\_\_\_ Message #: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

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

**1. IS STUDENT CURRENTLY UNDER GUARDIANSHIP:**  YES  NO **(If "YES" please answer question #2)**  
**In cases where custody/visitation affects the school, the school shall follow the most recent court order on file with the school. It is the responsibility of the custodial parent or parents having joint custody to provide the school with the most recent court order.**

**2. Does parent/s have any visitation rights:** Mother:  YES  NO Father:  YES  NO

**PART 4**

**Students Previous School Information**

Last School Attended: \_\_\_\_\_ Grade: \_\_\_\_\_

School Address: (City/State/Zip) \_\_\_\_\_

Date Withdrawn: \_\_\_\_\_ Has student ever attended Second Mesa Day School? Yes  No

Has student ever been retained: Yes  No  If "Yes" what grade: \_\_\_\_\_

**PART 5**

**Special Services** (please check all that apply) **\*\*IF you answered "YES" to any services below, please provide: (Most Current IEP or Name of School where services were rendered and a contact person)**

<b>SPECIAL EDUCATION</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>GIFTED &amp; TALENTED</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>PHYSICAL THERAPY</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>SPEECH THERAPY</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>OCCUPATIONAL THERAPY</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>COMPLETED HEADSTART</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>COUNSELING</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>SECTION 504 PLAN</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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

**PART 6**

**I (Parent/Guardian) am legally responsible for this student and hereby apply for his/her admission to this school. I understand that additional information may be requested by the school before the student is officially enrolled.**

**Signature of Parent/Legal Guardian**

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



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**SY 2024 - 2025**  
**STUDENT CHECK-OUT/**  
**BUS TRANSPORTATION**

**Student Name:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_

I (We) Parents/Guardians give authorization for the following listed individuals (below) to **CHECK-OUT** my/our child from school and/or **RECEIVE** them from the bus after school.

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

Parent/Guardian Phone Contact: \_\_\_\_\_

Please PRINT names clearly and list each individual separately (not as "Mr. & Mrs.")

**\*\* Only 5 Individuals will be allowed in addition to parent or guardian. (If you wish to make change to the list, please provide written letter and/or make changes with the Registrar)**

	Name of Individual	Relationship to Student	Phone Contact
1.	_____ / _____	_____ / _____	_____ / _____
2.	_____ / _____	_____ / _____	_____ / _____
3.	_____ / _____	_____ / _____	_____ / _____
4.	_____ / _____	_____ / _____	_____ / _____
5.	_____ / _____	_____ / _____	_____ / _____

**Bus Transportation Arrangement:**

Primary Pick-up location: \_\_\_\_\_

Primary Drop-off location: \_\_\_\_\_

**PLEASE READ & INITIAL**

- \*  Pick-Up & Drop-Off destination points will be scheduled as closest to student's residence. During bad weather months when off road/dirt roads get muddy– buses **WILL NOT** transport students on dirt roads. (Parents/Guardians will need to drop-off/pick-up students on paved roads).
- \*  Parents/Guardians – **PLEASE...have your children utilize the primary arrangements** – This will eliminate the over-crowding of buses and mix-ups with destination points. Unless there is an urgent or emergency need for alternate arrangement.
- \*  If student will be picked up or dropped-off at an alternative site due to **URGENT** or **EMERGENCY** situations, a written note is required from the primary as listed on the registration specifying the location and signed by the authorized parent or guardian. **ALL NOTIFICATIONS NEED TO BE TURNED INTO THE OFFICE BY 12:00 PM - NO LATER.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



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SY 2024 - 2025
PARENTAL CONSENT FORM
FIELD TRIPS AND SPORTS

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

I (We) hereby grant permission for my/our child to participate in an organized school sponsored activity trip as approved.
I (We) understand the students will be properly chaperoned and all precautions will be taken to insure his/her safety.

(NOTE TO PARENTS: Permission slips will be sent home prior to field trips.)

CHECK ONLY THOSE APPROPRIATE)

FIELD TRIPS

- Recreational, School Clubs, Overnight Trips, Out of State, On Reservation, Extra Curricular, Off Reservation

\*\*\*\*\*

I (We) hereby grant consent/permission/authorization for the following (Parents will be notified, if the following should occur)

- Transport student to nearest medical facility:
Hospital/Clinic to provide student with health services.
Emergency Medical Care (On and off the reservation)

Comments: \_\_\_\_\_

\*\*\*\*\*

I (We) hereby grant consent/permission/authorization for student to participate in the following competitive sports: (All sports participations will require a Physical Examination before student can participate)

- Basketball, Softball, Swimming, Cross Country, Soccer, Cheerleading, Volleyball, Flag Football, Chess

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



**SY 2023 - 2024  
Medical Attention Form**



**Student Name:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_

Second Mesa Day School provides a health care program for all our students. Clinical care will be provided during preset clinic hours by qualified and authorized medical personnel in the nurse’s station. Parents/Guardians must take students to the hospital/clinic for care during times when the nurse’s station is not staffed by the medical personnel.

The Nurse’s Station at Second Mesa Day School will include the following:

1. **EMERGENCY MEDICAL CARE** for accidents or serious illnesses occurring during school hours. When necessary, the student will be transported to the Hopi Health Care Center.
2. **ROUTINE HEALTH CARE**, including preventive health screening and health counseling. Available services may include immunizations, care for common adolescent physical concerns, drug and alcohol assessment and counseling. Dental care including sealants and preventive use of fluorides.
3. **CARE FOR NON-EMERGENT ILLNESSES**, including antibiotics and indicated medical prescriptions.
4. **IMMUNIZATIONS**, State Law requires that **ALL** school age children **MUST** have current immunization records on file to be enrolled or to attend school. Please bring your child’s immunization record with you during the enrollment process so the school can make a copy. (Please refer to the Arizona School Immunization Law for more information)
5. **VISION, HEARING AND SCOLIOSIS SCREENING** of selected students (in accordance with state regulations) and any student requesting an examination.
6. **SPORTS PHYSICALS** - Students who will be participating in any sports activities during the school year **2024-2025 MUST** have a physical done prior to start of any sport activities. Forms are available on the school website and at the school office. These physicals are good for one (1) year. It is best to try and schedule these physical appointments during the summer months to avoid delay in students’ sports participation.

All medical records will be kept confidential. No medical information will be shared between medical staff and school personnel. No elective procedures will be performed without parental permission. Students will be guaranteed confidential care in accordance with Arizona State Law.

I (We) fully understand all statements/guidelines indicated above and hereby grant permission for my child to receive full school services as described above while attending Second Mesa Day School.

I hereby give consent for all of the services listed above.

Exceptions or Special Instructions: \_\_\_\_\_

**In case of emergency, please provide emergency contact names and phone numbers of at least 3-4 names. Individuals must not have the same phone number. (Phone numbers must be current and working number at all times)**

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

**Phone#:** \_\_\_\_\_

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

**Phone#:** \_\_\_\_\_

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

**Phone#:** \_\_\_\_\_

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

**Phone#:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**SY 2024 - 2025**  
**Student Health History**  
**Part I**

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

Parent/Guardian Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Name of Family Physician/Dentist if other than PHS/IHS: \_\_\_\_\_

Family Physician/Dentist Phone #: \_\_\_\_\_

Please indicate the change in your child's health and date:

	Yes	No	Date		Yes	No	Date
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	_____	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____	JOINT PAINS	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	_____	KIDNEY TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____	SORE THROATS	<input type="checkbox"/>	<input type="checkbox"/>	_____
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	_____	BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____
MIGRANE HEAD ACHES	<input type="checkbox"/>	<input type="checkbox"/>	_____	SPINAL INJURIES	<input type="checkbox"/>	<input type="checkbox"/>	_____
BRAIN INJURY	<input type="checkbox"/>	<input type="checkbox"/>	_____	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Does your child wear prescriptive glasses:  YES  NO If "YES" indicate at what AGE: \_\_\_\_\_

Has your child had any surgery or operations:  YES  NO (If "Yes" please explain) \_\_\_\_\_

Has your child had any sprains or fractures?  YES  NO (If "Yes" please explain) \_\_\_\_\_

Is your child allergic to any medication?  YES  NO (If "Yes" please explain) \_\_\_\_\_

Does your child have any allergic reactions to certain foods or insect bites/stings?  YES  NO \_\_\_\_\_

Does your child use and asthma inhaler of any type?  YES  NO (If "Yes" please explain) \_\_\_\_\_

Has your child been diagnosed by Physician with ADHD?  YES  NO If "YES" Date Diagnosed: \_\_\_\_\_

List any other health concern not listed above: \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Administering Medicine**

**Part II**

**PRESCRIBED MEDICATIONS**

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

GRADE: \_\_\_\_\_

Medications may be administered to your child/children if you follow these simple guidelines:

1. The medication must be in its original container as prepared by a pharmacist and labeled with the patient's name with instructions, dosage compound contents and proportions clearly marked.
2. A parental permission form must be signed and on file.
3. All medications are to be given to the Medical Technician to be stored where it will be marked with the student's name and kept in a locked cabinet. Any medication remaining will be returned to the student at the end of the school year.

**\*\* Student's will not self-administer medication at school due to possible over dosage, and/or hinder complications. A SIGNED PHYSICIAN'S STATEMENT INDICATING THE NECESSITY MUST ACCOMPANY ANY REQUEST FOR SELF-ADMINISTERING OF PRESCRIBED MEDICATION.**

**PRESCRIBED MEDICATIONS**

Is your child currently taking prescribed medications:  Yes  No (If "NO" – PLEASE SIGN below and go to next page)

Type of Medication: \_\_\_\_\_

Diagnosis/reason for giving medication: \_\_\_\_\_

\_\_\_\_\_

Times medication is given: \_\_\_\_\_

Date: From: \_\_\_\_\_ To: \_\_\_\_\_

Hospital Name/City/State: \_\_\_\_\_

\_\_\_\_\_

Physician's Name: \_\_\_\_\_

**Thank you for completing this Health History. This will become part of your child's health record. Please let the schools know as soon as possible if there are any changes to the information you provided.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Second Mesa Day School

P.O. Box 98

Second Mesa, AZ 86043

Phone: (928) 737-2571

Fax: (928) 737-2565



Dear Parents/Guardians,

This letter is to inform you of the policy for the Second Mesa Day School Library books check out system.

1. Students will be coming to the library once a week to check out books and other materials.
2. These items will be due back in the library in one week.
3. It is expected that the items be returned in the same condition as when they were checked out.
4. If any items are lost or damaged, you as parents/guardians will be responsible for the cost of the item.
5. All students must return Library materials on the date they are due.



In addition to checking out books, the students will be learning Library skills, Library manners, and be introduced to the pleasure of reading. We hope that these experiences will prove enriching and develop lifelong reading appreciation.

We encourage all students to participate as library readers. Do all you can to encourage your child to read.

Thank You,

Librarian

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### *Second Mesa Day School Policy*

*I (we) hereby grant consent/permission/authorization for my child to participate in the school Library check out system and agree to abide by the above set policies for SY 2024-2025.*

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

Parent/Guardian Name (Please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Office Use - Only*

Student Enrollment Date: \_\_\_\_\_ Student ID# \_\_\_\_\_

Assigned Teacher: \_\_\_\_\_

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**SY 2024-2025**

**RELEASE OF RECORDS**  
**Office of Registrar**

**PARENT REQUEST FOR RELEASE OR EXCHANGE OF STUDENT INFORMATION**

**DATE OF 1<sup>st</sup> REQUEST:** \_\_\_\_\_ **DATE OF 2<sup>nd</sup> REQUEST:** \_\_\_\_\_ **DATE OF 3<sup>rd</sup> REQUEST:** \_\_\_\_\_

<b>Students Legal Name</b>	<b>Date of Birth</b>	<b>Grade</b>

**I AUTHORIZE:**

<b>Previous School Attended</b>		
<b>Address / City / State / Zip Code</b>		
<b>Phone</b>	<b>Fax</b>	<b>Email</b>

To Release and/or exchange the following information:

- School Academic History – Cumulative Records (Report Card, Test Scores, etc)
- Developmental/Medical Records (Immunizations, Physical, etc.)
- Attendance Records
- Behavioral/Disciplinary Records
- Individual Education Plan (IEP), Evaluation Reports
- Other \_\_\_\_\_

Please send requested information in reference to my son/daughter to:

<b>Please EMAIL records to:</b> <a href="mailto:Jolene.Lomakema@secondmesa.org">Jolene.Lomakema@secondmesa.org</a>	<b>OR</b>	<b>Second Mesa Day School</b> <b>PO Box 98</b> <b>Second Mesa, AZ 86043</b>	<b>PHONE: (928) 737-2571</b> <b>FAX: (928) 737-2565</b>
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I understand that information given and received will be used only by professional staff and will not be released to any other party or agency (other than another school) without my prior written consent. I am aware of my rights to review and obtain copies of these records if I so request.

<b>Parent/Legal Guardian Signature</b>	<b>Date</b>
<b>Address:</b>	<b>Phone:</b>

**\*\* This is in accordance with the Education Amendment Act of 1974.**

## 2023 Hopi Health Care Center School-Based Dental Disease Prevention Program

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade \_\_\_\_\_

The IHS Hopi Health Care Center Dental Clinic is excited to restart our school based outreach program with the intention of **screening for and preventing dental disease** (cavities). A licensed Indian Health Service doctor will be on site at all times to oversee all activities. This screening **DOES NOT** take the place of regular dental visits. For any further questions please call 928-737-6162.

Please Circle **One** of the Following:

**YES** - I am the legal caregiver and give my consent for the school-based dental screening program.

Or

**NO** - I do not want my child to participate in any school based dental outreach programs.

If **NO**, who is the child's regular dental provider: \_\_\_\_\_

The following preventive treatment **MAY** be provided as determined by the dentist on site:

- Dental Screening / Examination
- X-rays (as determined by dentist)
- Dental cleaning
- Dental Sealants (Small preventive fillings that do not require drilling into the tooth)
- Fluoride Varnish (for prevention of cavities)
- Oral Hygiene Instruction (teaching about how to clean your teeth)

**In urgent situations involving severe pain, infection, or trauma, EVERY ATTEMPT WILL BE MADE TO CONTACT THE CAREGIVER AT THE NUMBER BELOW prior to providing dental services.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contact Phone

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Influenza Vaccination Clinic  
2023-2024 PARENTAL CONSENT FORM**

**\*\*Regular Seasonal Flu \*\***

**Section 1: Information about Child to Receive Vaccine (please print)**

STUDENT INFORMATION		
<u>Last Name</u>	<u>First Name</u>	<u>Middle Initial</u>
<u>STUDENT'S DATE OF BIRTH</u> Month:          Day:          Year:		<u>STUDENT'S GENDER</u> Male or Female
<u>HHCC Chart #</u> Yes or No		
PARENT/LEGAL GUARDIAN		
<u>Last Name</u>	<u>First Name</u>	<u>Middle Initial</u>

**\*\*\* If this is the FIRST time your child (8 years old and younger) is receiving the Influenza vaccine, she/he is required to return to clinic for a booster in 4 weeks. Parent(s)/guardian(s) must make this arrangement. \*\*\***

The following questions will help us know if your child can get the 2023-2024 Influenza vaccine.

**Section 2: Child Health History**

	YES	NO
1. Does your child have a serious allergy to eggs?		
2. Does your child have any other serious allergies that you know of? If so, please list:		
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?		
4. Has your child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
5. Does your child have any chronic illnesses such as asthma, seizures, heart disease, or other medical conditions that require frequent doctor visits and medications? <b>If you indicate YES, your child will receive a shot.</b>		

**Section 3: Consent for Vaccination**

<input type="checkbox"/> <b>I GIVE CONSENT:</b>	I have read and understand the VIS on Inactivated Influenza Vaccine.	
<input type="checkbox"/> <b>I DECLINE:</b>	_____	_____
	Signature of Parent / Legal Guardian	Date
	_____	
	Phone Number	

**Please return to your child's school as soon as possible.**

For more information about the 2023-2024 Seasonal Influenza vaccine, please call the Hopi Health Care Center at (928) 737-6257.



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School Year 2024-2025  
 (New forms must be completed every year)

**PARENT/GUARDIAN CONSENT TO ADMINISTER OVER-THE-COUNTER MEDICATION**

STUDENT NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

Over-The-Counter (OTC) medications are drugs that do not require a doctor's prescription. This form is required before over-the-counter medications can be administered to your child at school. Medical personnel in the medical office or designated personnel will administer medication to your child.

**PLEASE CHECK MARK EACH MEDICATION FOR WHICH YOU ARE GIVING CONSENT FOR YOUR CHILD**

\_\_\_\_\_ I consent to all over-the-counter medications checked marked below.

\_\_\_\_\_ I DO NOT give consent to any over-the-counter medications.

**TOPICAL**

- \_\_\_\_\_ Antibiotic Cream (i.e. Bacitracin Cream, Polysporin)
- \_\_\_\_\_ Hydrocortisone Cream (i.e. Cortaid)
- \_\_\_\_\_ Oral products containing benzocaine (i.e. Oragel)
- \_\_\_\_\_ Burn Gels
- \_\_\_\_\_ Eye Drops for dryness (Visine, Sterile NS Eye Drops)

**ORAL**

- \_\_\_\_\_ Acetaminophen (i.e. Tylenol)
- \_\_\_\_\_ Antacid (i.e. Mylanta, Maalox, Tums, Pepto)
- \_\_\_\_\_ Cold Medicine (i.e. guaifenesin, pseudoephedrine, phenylephrine)
- \_\_\_\_\_ Antihistamine (i.e. Benadryl)
- \_\_\_\_\_ Cough Syrup (i.e. Dextromethorphan – Plain or medicated cough drops)

Please check with Second Mesa Day School Medical Office to see which medications are available at the school or which medication you will need to supply for your child. Over-the-counter medications will be administered according to the manufacturer's recommended dosage.

I Parent/Guardian give consent to SMDS Medical Staff and/or designated personnel to administer the above checked marked medications to my child on as needed basis only.

\_\_\_\_\_  
 (Signature of Parent or Legal Guardian)

\_\_\_\_\_  
 (Date)

*When sending OTC medications to the school not listed above, it must be in the original manufacturer's container with the label intact, otherwise it will not be accepted. For safety reasons, Parents and/or Legal Guardians must bring the medication directly to the school medical office.*



State of Arizona  
Department of Education

Office of English Language Acquisition Services



**Primary Home Language Other Than English (PHLOTE)  
Home Language Survey**  
(Effective April 4, 2011)

These questions are in compliance with Arizona Administrative Code, R7-2-306(B)(1), (2)(a-c).

Responses to these statements will be used to determine whether the student will be assessed for English Language Proficiency.

1. What is the primary language used in the home regardless of the language spoken by the student? \_\_\_\_\_
2. What is the language most often spoken by the student? \_\_\_\_\_
3. What is the language that the student first acquired? \_\_\_\_\_

Student Name \_\_\_\_\_ District \_\_\_\_\_  
Student ID \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSID \_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
District or Charter \_\_\_\_\_  
School \_\_\_\_\_

Please provide a copy of the Home Language Survey to the EL Coordinator/Main Contact on site.

In AzEDS, please indicate the student's home or primary language. (Revised 01-2019)



### Student Residency Verification Document

This document is intended to address the McKinney-Vento Act. This document will be used by school personnel and partnering agencies to ensure all providers have the necessary information to help support your child (student) and his/her family.

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_

Male  Female Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Name of Parent(s)/Legal Guardian(s) \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Phone Contacts: \_\_\_\_\_

1. Presently, where is the student living? *Check one box* in Section A or Section B

Section A	Section B
<input type="checkbox"/> In a shelter; <input type="checkbox"/> With more than one family in a house or apartment; <input type="checkbox"/> In a motel, car or campsite; <input type="checkbox"/> With friends or family members (other than parent/guardian) <div style="background-color: yellow; padding: 2px;"><b>Continue: if you checked a box in Section A, Complete #2 and the remainder of this form</b></div>	<input type="checkbox"/> Choices in Section A do not apply  <p><b><u>STOP:</u> If you checked this this box section, you do <u>not</u> need to complete the remainder of this form, please sign/date and submit to school personnel.</b></p>

2. The student lives with:

- |                                                   |                                                                            |
|---------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> 1-parent                 | <input type="checkbox"/> a relative, friend(s) or other adult(s)           |
| <input type="checkbox"/> 2-parents                | <input type="checkbox"/> alone with no adults                              |
| <input type="checkbox"/> 1 parent & another adult | <input type="checkbox"/> an adult that is not the parent or legal guardian |

Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

School Use Only-School Administrator's determination of Section A circumstances:

**If the parent has checked Section B above, completion of this form is not required. For any choices in Section A, this form must be completed and provided to School Registrar immediately upon completion. Form will be kept separately from Student Permanent Record for audit purposes during the year. SMDS Parent Liaison may be notified about family's situation.**





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## Internet Acceptable Use Policy

Second Mesa Day School (SMDS) offers staff and students access to a computer network for educational and instructional purposes. In addition, SMDS offers staff and students access to the Internet. Internet access is intended to promote, enhance, and support educational goals and objectives. To gain access to the SMDS network and the Internet, all students under the age of 18 must obtain parental permission. All staff, students, visitors, vendors/contractors must sign the Internet Acceptable Use Policy, if they are going to access the school internet onsite. A copy of the IAUP signed by a staff member will be kept at the personnel office. Students 18 and over may sign their own forms.

### CIPA COMPLIANCE

Second Mesa School has and will continue to comply with the requirements of the Children’s Internet Protection Act, (CIPA) as codified at 47 U.S.C. § 254(h) and (l). SMDS is committed to assuring the safe conduct of all students while online and has a comprehensive policy about the proper use of our technological resources. At the beginning of each school year, students and staff are made aware of SMDS Internet Acceptable Use Policy. In addition, each student’s parent and/or guardian must sign and Internet use agreement before they are allowed access to the Internet and the SMDS network. It is the SMDS’s intent to preserve network bandwidth and improve network response times by limiting Internet access to educational-related sites. The filtering software used to block and filter access to the Internet from pornographic and obscene sites is SMDS’s DNS Filter, ensuring compliance with distract policies and maintaining a positive online environment.

### INTERNET SERVICES

Access to the Internet expands classroom and library media resources. These enable staff and students to explore thousands of libraries, databases, and other information resources. These resources can be used for individual and group projects, collaborations, curriculum materials and idea sharing.

### INTERNET RESPONSIBILITIES

With access to the Internet comes responsibility. SMDS has installed an Internet filtering application and a Firewall to help protect students from inappropriate material while they are accessing Internet resources at school. Filtering is effective but not perfect. Staff must be vigilant in monitoring student use of technology systems and prepared to enforce the guidelines found within this policy (IAUP). Parents and guardians of minors are responsible for setting and conveying the standards that their children should follow when using any media and informational sources. Students are responsible for appropriate behavior when using electronic devices and resources. When signing the Internet Acceptable Use Policy, the students and parent agree to abide by the policies set forth by SMDS.

SMDS is held harmless and released from liability for ideas and concepts that students gain by their use of the Internet.

## SMDS NETWORK SERVICES

Each staff member and student are provided with a network account, which allows access to the SMDS network and services. This access to network services is provided for those who agree to act in a considerate and responsible manner. Access is a privilege, not a right. Network accounts provide for a limited amount of personal storage space (SMDS Share Folder) on the SMDS network for files related to the pursuit of education, which should be maintained by periodically clearing out older files.

It is important for staff and students to keep passwords secure and private. However, all users should be aware that teachers and administrators have the right to review files to maintain system integrity and to be sure that the system is being used according to the SMDS Board policy.

SMDS employs an extensive back-up of data each week. Copies are stored both on-site and off-site for additional security. Employee files can be saved if saved to their Network Share Folder.

## SMDS NETWORK ACCESS RESPONSIBILITIES

Individual user of SMDS technology is responsible for their behavior and communication over those networks. Users will only use their personal Network ID to login to the SMDS network (some elementary students will use a generic classroom ID). When signing the IAUP users agree to comply with SMDS rules and policies.

SMDS makes no warranties of any kind either expressed or implied, for the provided access. The staff, school and SMDS are not responsible for any damages incurred, including, but not limited to, the lost of data stored on SMDS resources, to personal property used to access SMDS resources, or for the accuracy, nature or quality of information stored on SMDS resources.

## RESTRICTIONS

The following activities are not permitted on SMDS electronic resources:

- Accessing, uploading, downloading, transmitting, displaying, or distributing obscene or sexually explicit material.
- Accessing, uploading, downloading, transmitting, displaying, or distributing unauthorized files or applications of any kind (including but not limited to games, IM clients, VPN's, and Internet Proxies).
- Transmitting obscene, abusive, or sexually explicit language.
- Damaging or vandalizing computers, computer systems, computer networks or computer files.
- Debilitating, disabling, or altering computers, systems, or networks.
- Creating, downloading, or distributing computer viruses or parts of computer viruses.
- Violating copyright or otherwise using another person's intellectual property without his or her prior approval and or proper citation.
- Using another person's account, password, folder, work, or files.
- Intentionally wasting computer network or printer resources.
- Using the SMDS network or equipment for personal, commercial, or political purposes.
- Violating local, state, or federal statutes.

## CONSEQUENCES FOR IMPROPER USE

Inappropriate use of SMDS technology will result in the restriction or cancellation of the user's account. Violation of the IAUP may lead to disciplinary and/or legal action, including but not limited to suspension, expulsion and termination, or criminal prosecuting by government authorities.

SECOND MESA DAY SCHOOL  
Internet Acceptable Use Policy  
Agreement

USER AGREEMENT

As a user of Second Mesa Day School's computer network, I agree to comply with the Internet Acceptable Use (IAUP). I will use the SMDS network and the Internet in a constructive and appropriate manner. Should I commit any violation, my access privileges may be revoked, and disciplinary action will be taken.

STAFF MEMBER

STUDENT

OTHER USER

USER (Please Print) \_\_\_\_\_

USER SIGNATURE: \_\_\_\_\_

STAFF POSITION/HOMEROOM TEACHER: \_\_\_\_\_

**SMDS STUDENTS AND PARENTS WILL COMPLETE THIS PAGE WITH THEIR SIGNATURE FORM FOR REGISTRATION.**

As parent or legal guardian of the student above, I have read and understood the SMDS Internet Acceptable Use Policy.

\_\_\_\_\_ I grant permission for my child to access the SMDS network and Internet resources. I understand that he/she is expected to use good judgement and follow rules and guidelines when using the SMDS network and Internet resources. I agree to comply with the SMDS Internet Acceptable Use Policy (IAUP)

\_\_\_\_\_ I DO NOT grant permission for my child to access Internet resources while at school. I understand that my child will still have access to the SMDS network and is expected to follow the rules and guidelines for the appropriate use of the network as stated in the Internet Acceptable Use Policy (IAUP).

Parent Name (please print) \_\_\_\_\_

Parent Signature: \_\_\_\_\_

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



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 Second Mesa, AZ 86043  
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## **STUDENT USAGE AGREEMENT**

1. I WILL USE THE INTERNET ONLY FOR SCHOOL PURPOSES.
2. I WILL USE THE INTERNET FOR LEARNING OR RESEARCH APPROVED BY A TEACHER.
3. I WILL RESPECT THE PRIVACY OF OTHER COMPUTER USERS AND WILL NOT OPEN, CHANGE OR REMOVE ANYONE ELSE’S FILES OR WORK.
4. I WILL ALWAYS USE APPROPRIATE LANGUAGE WHEN WRITING OR COMMUNICATING ON THE INTERNET.
5. I WILL NOT GIVE MY NAME, ADDRESS, SCHOOL OR TELEPHONE NUMBER TO ANYONE ON THE INTERNET.
6. I WILL NOT TAKE ANY MATERIAL THAT I COPY FROM THE INTERNET AS MY OWN. IF I COPY ANYTHING FROM THE INTERNET FOR MY SCHOOL ASSIGNMENTS, I WILL GIVE CREDIT TO THE AUTHOR.
7. I WILL FOLLOW THE INTRUCTIONS OF MY TEACHER, TEACHER ASSISTANTS, LIBRARY AND COMPUTER LAB STAFF OR OTHER SCHOOL EMPLOYEES WITH RESPECT TO USING COMPUTERS, SOFTWARE OR THE SMDS NETWORK.
8. I WILL RESPECT AND SHOW PROPER CARE AND HANDLING OF ALL EQUIPMENT.
9. I WILL NOT WASTE PAPER AND INK BY PRINTING THINGS I DO NOT NEED FOR MY SCHOOL WORK.
10. I WILL NOT HARM OR DESTROY ANY EQUIPMENT OR INFORMATION ON PURPOSE.
11. I WILL NOT CHANGE ANY SETTINGS ON ANY SCHOOL COMPUTERS WITHOUT PERMISSION FROM BY TEACHER OR COMPUTER LAB STAFF.

Even with the above provisions, we cannot guarantee that a student will not gain access to objectionable material on the Internet. It is our expectation that students will use network resources and the Internet in a responsible manner. Students who will fully misuse available technology or network access will face disciplinary actions that may include loss of computer privileges.

Student’s Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ Student ID: \_\_\_\_\_

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date



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**Appendix X-A**

**PERMISSION AND RELEASE TO PUBLISH  
 ON THE INTERNET OR RADIO BROADCAST**

All works including photographs that are published on the school website will be only in a group setting. If a student’s sole photograph is published, this document will be referenced, and the school will adhere to the parent or guardian’s request as indicated below:

As a parent or guardian of \_\_\_\_\_ Grade: \_\_\_\_\_,  
 I understand the benefits and risks of publishing on the Internet. In consideration of the benefits of allowing my child’s his/her work, first/last name and/or picture on the school’s web and Bobcat news (FB) page, I elect the following:

I give permission to publish my child’s.

- FIRST NAME ONLY* on the school website and Bobcat News.
- FIRST and LAST NAME* on the school website and Bobcat News.
- FIRST NAME ONLY and PHOTOGRAPH* on the school’s website and Bobcat News.
- FIRST and LAST NAME and PHOTOGRAPH* on the school website and Bobcat News.
- FIRST and LAST NAME on Radio Broadcast (KUYI) for SMDS only.*

Further, I accept full responsibility for the publication as set forth in the publication and agree to release and hold the school harmless from all damages or injury to me or to the student arising from said publication.

PARENT/GUARDIAN

Printed Name: \_\_\_\_\_

PARENT/GUARDIAN

Signature: \_\_\_\_\_

DATE: \_\_\_\_\_



**ARIZONA INTERSCHOLASTIC ASSOC.**  
7007 N. 18TH ST., PHOENIX, AZ 85020  
PHONE: (602) 385-3810

**2024-25**  
**ANNUAL PREPARTICIPATION**  
**PHYSICAL EVALUATION**



**EXCLUSIVE URGENT CARE**  
**PARTNER OF THE AIA**

(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: \_\_\_\_\_  
Sex Assigned at Birth: \_\_\_\_\_  
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?	<input type="checkbox"/>	<input type="checkbox"/>
2) List past and current medical conditions: _____		
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): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection		
7) Have you ever had surgery? (Please list): _____	<input type="checkbox"/>	<input type="checkbox"/>
8) 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 10)	<input type="checkbox"/>	<input type="checkbox"/>
9) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 10):	<input type="checkbox"/>	<input type="checkbox"/>
10) 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):	<input type="checkbox"/>	<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"/> Lower 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		

	Y	N
11) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
12) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
13) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
14) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
15) Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
16) Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>
17) Do you have groin or testicular pain, or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
18) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
19) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
20) Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
21) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
22) 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"/>
23) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
24) 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"/>
25) While exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
26) 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"/>
27) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
28) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
29) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
30) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
31) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
32) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

**Females Only**

	Y	N
37) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
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**

The physician should fill out this form with assistance from the parent or guardian.)

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

Date of Birth: \_\_\_\_\_

### Patient History Questions: Please Share 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"/>

#### Explain "Yes" Answers Here

### COVID-19

	Y	N
1) Was your child hospitalized as a result for complications of COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child had any long-term complications from COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
3) Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist) to be cleared to return to sports?	<input type="checkbox"/>	<input type="checkbox"/>

#### Explain "Yes" Answers Here





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2024-25  
ANNUAL PREPARTICIPATION  
PHYSICAL EVALUATION



EXCLUSIVE URGENT CARE  
PARTNER OF THE AIA

## Patient Health Questionnaire Version 4 (PHQ-4)

Over the last two weeks, how often have you been bothered by any of the following problems? (circle responses)

	Not At All	Several Days	Over Half The Days	Nearly Every Day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

If you score a sum of 3 or greater on either questions 1 and 2, or 3 and 4, you may have anxiety or depression that is affecting you more than normal. In this case, it is recommended that you talk to a trusted health care provider such as your primary care physician, your athletic trainer at school, or a counselor at school. If there is not someone you feel comfortable talking to or you are interested in learning more to help yourself or a friend, please use the resources provided below.

For more information regarding student-athlete mental health:  
[Quiet Suffering - A Resource for Student-Athlete Mental Health](https://spark.adobe.com/page/lltwyoLpTAp0V/)  
[spark.adobe.com/page/lltwyoLpTAp0V/](https://spark.adobe.com/page/lltwyoLpTAp0V/)

Teen Lifeline Call and Text Crisis Line  
(602) 248-8336 (TEEN)

Outside Maricopa county call: 1-800-248-8336 (TEEN)

Hours are: Call 24/7/365 | Text weekdays 12-9 p.m. & weekends 3-9 p.m. | Peer counseling 3-9 p.m. daily

Crisis text line: Text HOME to 741741 to connect with a crisis counselor

National Suicide Prevention Lifeline  
988 or [suicidepreventionlifeline.org](https://suicidepreventionlifeline.org)

The Trevor Lifeline  
866-488-7386 (for gender diverse youth)





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**2024-25**  
**ANNUAL PREPARTICIPATION**  
**PHYSICAL EXAMINATION**



**EXCLUSIVE URGENT CARE**  
**PARTNER OF THE AIA**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_  
 BP: \_\_\_\_ / \_\_\_\_ (\_\_\_\_ / \_\_\_\_ / \_\_\_\_)  
 Corrected: Y  N   
 Vision: R20/\_\_\_\_ L20/\_\_\_\_  
 Pupils: Equal  Unequal

	Normal	Abnormal Findings	Initials *
<b>Medical</b>			
Appearance	<input type="checkbox"/>		
Eyes/Ears/Throat/Nose	<input type="checkbox"/>		
Hearing	<input type="checkbox"/>		
Lymph Nodes	<input type="checkbox"/>		
Heart	<input type="checkbox"/>		
Murmurs	<input type="checkbox"/>		
Pulses	<input type="checkbox"/>		
Lungs	<input type="checkbox"/>		
Abdomen	<input type="checkbox"/>		
Genitourinary &	<input type="checkbox"/>		
Skin	<input type="checkbox"/>		
<b>Musculoskeletal</b>			
Neck	<input type="checkbox"/>		
Back	<input type="checkbox"/>		
Shoulder/Arm	<input type="checkbox"/>		
Elbow/Forearm	<input type="checkbox"/>		
Wrist/Hands/Fingers	<input type="checkbox"/>		
Hip/Thigh	<input type="checkbox"/>		
Knee	<input type="checkbox"/>		
Leg/Ankle	<input type="checkbox"/>		
Foot/Toes	<input type="checkbox"/>		

\* - Multi-examiner set-up only | & - Having a third party present is recommended for the genitourinary examination

NOTES:

Cleared Without Restriction   
 Cleared With Following Restriction: \_\_\_\_\_  
 Not Cleared For:  All Sports  Certain Sports: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of:

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

Name of Physician (Print/Type): \_\_\_\_\_ Exam Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Signature of Physician: \_\_\_\_\_, MD/DO/ND/NMD/NP/PA-C/CCSP

## 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: \_\_\_\_\_