



SECOND MESA DAY SCHOOL

"ITAH TSATSAYOM MOPEKYA"

Paulesha Sewemaenewa, Board Presiden
Lynette Shupla, Board Membe
Meridith Van Winkle, Board Membe
Laila Sabori, Board Membe
Anita Bahnimptewa, Board Membe
Kimberly K. Thomas, Chief School Administrato

May 13, 2025

Dear Parents/Guardians:

THANK YOU and WELCOME BACK to Second Mesa Day School, *"HOME OF THE MIGHTY BOBCATS!"* We look forward to another great successful school year **2025-2026**.

This packet will serve as your formal confirmation that your child has been invited to return to Second Mesa Day. School for the 2025-2026 school year.

The check-off list will be used as a guide for completing your child's enrollment. All forms must be completed and signed with all required documents on file to be considered complete.

Our first day of school is scheduled to start on Monday, August 4, 2025.

SMDS continues to encourage all parents/guardians and families to be engaged with their 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! *"ITAH TSATSAYOM MOPEKYA"*

Sincerely,

Mrs. Kimberly Thomas, Principal/CSA
Second Mesa Day School

SECOND MESA DAY SCHOOL | SY 2025-2026

- 04 Independence Day
- 8 School Board Meeting
- 21-31 Staff Orientation

| JULY '25 | | | | | | |
|----------|----|----|----|----|----|----|
| S | M | T | W | Th | F | S |
| | | 1 | 2 | 3 | 4 | 5 |
| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | 31 | | |

| JANUARY '26 | | | | | | |
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| 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | 31 |

- 01 New Year's Day
- 5 School Resumes
- 8 Pawsome Cats
- 13 School Board Meeting
- 14 PAC Meeting
- 16 PD (Curriculum & Instr.)
- 19 M.L. King Day
- 30 PD (School Improvement)

- 1 Staff Orientation
- 4 First Day of School
- 8 Pueblo Revolt Day
- 12 School Board Meeting
- 13 PAC Meeting
- 15 PD (Curriculum & Instr.)
- 29 PD (Sch. Improvement)

| AUGUST '25 | | | | | | |
|------------|----|----|----|----|----|----|
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| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | | | | | | |

| FEBRUARY '26 | | | | | | |
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| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| | | | | | | |

- 5 Pawsome Cats
- 10 School Board Meeting
- 11 PAC Meeting
- 16 Presidents' Day
- 27 PD (School Improvement)

- 01 Labor Day
- 4 Pawsome Cats
- 9 School Board Meeting
- 10 PAC Meeting
- 12 PD (Curriculum/Instr.)
- 26 PD (Sch. Improvement)
- 30 PTC

| SEPTEMBER '25 | | | | | | |
|---------------|----|----|----|----|----|----|
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| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
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| MARCH '26 | | | | | | |
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| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

- 5 3rd Quarter Ends
- 5 Pawsome Cats
- 10 School Board Meeting
- 9-12 Spring Break
- 18 PAC Meeting
- 17-19 PTC

- 1-2 PTC
- 8 PAC Meeting
- 9 1st Quarter Ends
- 10 PD (Curriculum & Instr.)
- 13 Fall Break
- 14 School Board Meeting
- 24 PD (Sch. Improvement)

| OCTOBER '25 | | | | | | |
|-------------|----|----|----|----|----|----|
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| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | 31 | |

| APRIL '26 | | | | | | |
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| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

- 2 Pawsome Cats
- 8 PAC Meeting
- 10 PD (Curriculum & Instr.)
- 14 School Board Meeting
- 24 PD (School Improvement)

- 6 Pawsome Cats
- 7 PD (Curriculum & Instr.)
- 11 School Board Meeting
- 11 Veteran's Day
- 12 PAC Meeting
- 21 PD (Sch. Improvement)
- 27 Thanksgiving Day
- 28 Thanksgiving Break

| NOVEMBER '25 | | | | | | |
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| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
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| 30 | | | | | | |

| MAY '26 | | | | | | |
|---------|----|----|----|----|----|----|
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| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | | | | | | |

- 7 Pawsome Cats
- 8 PD (Curriculum & Instr.)
- 12 School Board Meeting
- 13 PAC Meeting
- 19 6th Grade Promotion
- 20 Last Day of School

- 2-4 PTC
- 5 PD (Curriculum & Instr.)
- 9 School Board Meeting
- 10 PAC Meeting
- 18 2nd Quarter Ends
- 25 Christmas Day
- 22-31 Winter Break

| DECEMBER '25 | | | | | | |
|--------------|----|----|----|----|----|----|
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| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | 31 | | | |

| JUNE '26 | | | | | | |
|----------|----|----|----|----|----|----|
| S | M | T | W | Th | F | S |
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| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | | | | |

- 19 Juneteenth

Governing Board Approved:
May 6, 2025



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RETURNING STUDENT Registration Checklist

SCHOOL YEAR 2025-2026

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/Transportation Form

____ McKinney-Vento Form

____ Medical Attention Form

____ Physical Examination Form

____ Student Health History-Part I & II

____ Library Permission Form

***** These items are mandatory at time of enrollment.
Student will NOT start school if documents are
not on file. Please check with Registrar.***

____ HHCC Dental Screening Form

____ HHCC Influenza Vaccination Form

____ Guardian Affidavit – if applicable (1 page)

____ OTC Medication Consent

____ Updated Immunization Record ***(Mandatory)***

____ Home Language Survey Form

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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SY 2025 - 2026 ** Returning Student ** Enrollment Application

Student Identification:

Student Full Name: _____ Grade Applying _____

Mailing Address (PO Box, City, State, Zip) _____

Home Physical Address: _____

Community/Village student resides in: _____

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

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

Mother: ☐ Father: ☐ Both Parents: ☐ Grandparents: ☐ Guardian: ☐

Other: ☐ (Specify) _____

PRIMARY #1: Parent / Legal Guardian Information

1. NAME: _____

2. Relationship to Student: _____

3. Home#: _____

4. Cell#: _____

5. Work#: _____

6. Message #: _____

7. Email: _____

PRIMARY #2: Parent / Legal Guardian Information

1. NAME: _____

2. Relationship to Student: _____

3. Home#: _____

4. Cell#: _____

5. Work#: _____

6. Message #: _____

7. Email: _____

IS STUDENT CURRENTLY UNDER GUARDIANSHIP? ☐ YES ☐ NO

If "YES" Does parent/s have any visitation rights: Mother: ☐ YES ☐ NO Father: ☐ YES ☐ NO
(Please provide legal documentation)

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.

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 2025-2026 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.)

FIELD TRIPS

(CHECK ONLY THOSE APPROPRIATE)

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Recreational | <input type="checkbox"/> Overnight Trips | <input type="checkbox"/> On Reservation | <input type="checkbox"/> School Clubs |
| <input type="checkbox"/> Off Reservation | <input type="checkbox"/> Out of State | <input type="checkbox"/> Extra Curricular | |

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

- ☐ Transport student to medical facilities:
☐ Hospital/Clinic to provide student with health services.
☐ Emergency Medical Care

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)

- | | | | | |
|---------------------------------------|-------------------------------------|--|--|---------------------------------|
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Softball | <input type="checkbox"/> Swimming | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Soccer |
| <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Flag Football | | |

Signature of Parent/Legal Guardian: _____ Date _____

Post Office Box 98 | Second Mesa, Arizona 86043
Direct Number: (928) 737-2571 | Fax Number: (928) 737-2565
Website: www.secondmesadayschool.com



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Kimberly K. Thomas, *Chief School Administrator*

SY 2025 - 2026 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.

Students Bus Transportation Arrangement:

Primary Pick-up location: _____

Primary Drop-off location: _____

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

**** Only 5 Individuals will be allowed (If you wish to change the list, please provide letter and/or make Changes with Registrar's Office).**

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

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 overcrowding 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 _____



SY 2025 - 2026 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 require 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 **SY 2025-2026 MUST** have a physical done prior to the 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 to 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: _____

Valid Until: June 30, 2026



SECOND MESA DAY SCHOOL

P.O. Box 98

Second Mesa, Arizona 86043

(928) 737-2571 / Fax (928) 737-2565



SY 2025 - 2026 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:

IF NO CHANGE FROM LAST YEAR - CHECK BOX / SIGN AT BOTTOM AND GO TO NEXT PAGE. ☐

| | Yes | No | Date |
|---------------------|--------------------------|--------------------------|-------|
| ANEMIA | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ARTHRITIS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ASTHMA | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| HEPATITIS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| SEIZURES | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| MIGRAINE HEAD ACHES | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| BRAIN INJURY | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| HEART PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

| | Yes | No | Date |
|-----------------|--------------------------|--------------------------|-------|
| TUBERCULOSIS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| JOINT PAINS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| KIDNEY TROUBLE | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| SORE THROATS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| BACK PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| SPINAL INJURIES | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| DIABETES | <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 To Students Part II

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 patient's name with all directions, 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 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: _____



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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

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 2025-2026.

Student Name: _____ GRADE: _____

Parent/Guardian (Please print): _____

Parent/Guardian Signature: _____ Date: _____

Office Use - Only

Student Enrollment Date: _____ Student ID# _____

Assigned Teacher: _____

2025-26 Hopi Health Care Center School-Dental Disease Prevention Program

Name of Child/Student: _____

Date of Birth: _____ School: _____ 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 parent/ legal caregiver and give my consent for the school-based dental screening program. (patients may continue to see their pediatric dentist elsewhere.)

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
- 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

Clearly Print Name

Contact Phone

Notes: _____



Influenza and COVID Vaccination Clinic

2025-2026 PARENT CONSENT FORM

Section 1: Information about Student to Receive Vaccine(s) - (please print)

| STUDENT INFORMATION | | |
|--------------------------------|---------------------|---|
| <u>Last Name</u> | <u>First Name</u> | <u>Middle Initial</u> |
| <u>Student's Date of Birth</u> | <u>HHCC Chart #</u> | <u>Student's Gender</u> Male or Female |
| PARENT / LEGAL GUARDIAN | | |
| <u>Last Name</u> | <u>First Name</u> | <u>Middle Initial</u> |

Section 2: Student Health History

| | YES | NO |
|---|-----|----|
| 1. Does the student have a serious allergy to eggs or previous dose of Flu? | | |
| 2. Is the student sick today? | | |
| 3. Does the student have allergies to medications, food or other: (if yes, please list below) | | |
| 4. Has the student had a serious reaction to any vaccine in the past? | | |
| 5. Last dose of the COVID-19 vaccination? _____ | | |
| 6. Does the student have a health condition or undergoing treatment (i.e. cancer, leukemia, or AIDS), that makes them moderately or severely immunocompromised? | | |
| 7. Has the student had a allergic reaction to any component or previous dose of the COVID-19 vaccine? | | |
| 8. Does the student take Cortisone, Prednisone, other steroids, anti-cancer drugs or x-ray treatments? | | |
| 9. Has the student received a transfusion of blood plasma or a medicine called Gamma Globulin? | | |
| 10. Is the student pregnant or at risk of becoming pregnant within the next month? ** First day of Last Menstrual Period (Date): _____ ** | | |

Section 3: Consent for Immunization(s) - VIS form(s) provided at time of vaccination.

| | |
|--|------------------------|
| <input type="checkbox"/> I GIVE CONSENT FOR: | |
| <input type="checkbox"/> DECLINE: | |
| _____ Flu | _____ COVID Monovalent |
| _____ Signature of Parent / Legal Guardian | _____ Date |
| ** Parent/Legal Guardian Contact Phone #: _____ | |

Please return consent to the student's school as soon as possible.

For more information about the immunizations, please call the Hopi Health Care Center PHN office at (928) 737-6257.



Second Mesa Day School
P.O. Box 98
Second Mesa, AZ 86043
Phone: (928)737-2571 Fax: (928)737-2565
Home of the Mighty Bobcats
"ITAH TSATSAYOM MOPEKYA"



School Year 2025-2026
(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. (effective 4/4/11)



SECOND MESA DAY SCHOOL

"ITAH TSATSAYOM MOPEKYA"

Paulesha Sewemacnewa, Board President
Sherry Lomayestewa, Board Member
VACANT, Board Member
VACANT, Board Member
Jasmine Dashec, Board Member
Kimberly K. Thomas, School Principal

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) Continue: if you checked a box in Section A , Complete #2 and the remainder of this form | <input type="checkbox"/> Choices in Section A do not apply STOP: If you checked this this box section, you do not need to complete the remainder of this form, please sign/date and submit to school personnel. |

2. The student lives with:

☐ 1-parent

☐ 2-parents

☐ 1 parent & another adult

☐ a relative, friend(s) or other adult(s)

☐ alone with no adults

☐ 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.

P.O. Box 98 Second Mesa, Arizona 86043

Phone: 928-737-2571

Fax: 928-737-2565



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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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STUDENT USAGE AGREEMENT

1. I WILL USE THE INTERNET ONLY FOR SCHOOL PURPOSES.
2. I WILL USE THE INTERNET FOR LEARNING, 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.



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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

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.



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- ☐ ***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: _____

AIA

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

2025-26

ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

NextCare **URGENT CARE**

**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.

| | Yes | No |
|--|--------------------------|--------------------------|
| 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: | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| 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 | | |

AIA

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ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

NextCare **URGENT CARE**

EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

| | Yes | No |
|---|--------------------------|--------------------------|
| 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) Have you or someone in your family tested positive for sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27) Have you been hospitalized or had long-term complication care due to COVID-19? | <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

Explain "Yes" Answers Here

| | Yes | No |
|--|--------------------------|--------------------------|
| 33) Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34) How old were you when you had your first menstrual period? | _____ | |
| 35) How many periods have you had in the last year? | _____ | |



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ANNUAL PREPARTICIPATION
PHYSICAL EVALUATION

NextCare
URGENT CARE

EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

Student Name: _____

Date of Birth: _____

Patient History Questions: Please Share About Your Child

| | Yes | No |
|---|--------------------------|--------------------------|
| 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

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 |

Share Any Notes Related To The Above Section



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ANNUAL PREPARTICIPATION
PHYSICAL EVALUATION

NextCare
URGENT CARE

EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

Family History Questions: Please Share About Any Of The Following In Your Family

| | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents, drowning or near drowning) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 2) Are there any family members who died suddenly of "heart problems" before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 3) Are there any family members who have unexplained fainting or seizures? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 4) Are there any relatives with certain conditions, such as: | | | | | |
| Enlarged Heart | <input type="checkbox"/> | <input type="checkbox"/> | Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertrophic Cardiomyopathy (HCM) | <input type="checkbox"/> | <input type="checkbox"/> | Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) | <input type="checkbox"/> | <input type="checkbox"/> |
| Dilated Cardiomyopathy (DCM) | <input type="checkbox"/> | <input type="checkbox"/> | Marfan Syndrome (Aortic Rupture) | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Rhythm Problems | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack, Age 50 or Younger | <input type="checkbox"/> | <input type="checkbox"/> |
| Long QT Syndrome (LQTS) | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker or Implanted Defibrillator | <input type="checkbox"/> | <input type="checkbox"/> |
| Short QT Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | Deaf at Birth | <input type="checkbox"/> | <input type="checkbox"/> |
| Brugada Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Explain "Yes" Answers Here

Additional History

| | Yes | No |
|--|--------------------------|--------------------------|
| 1) Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Do you drink alcohol or use illicit drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Have you ever taken anabolic steroids or used any other performance-enhancing supplements? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Have you ever taken any supplements to help you gain or lose weight, or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Do you always wear a seatbelt while in a vehicle? | <input type="checkbox"/> | <input type="checkbox"/> |

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 Student-Athlete

Signature of Parent/Guardian

Date

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: _____

AIA

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 PHONE: (602) 385-3810

2025-26**CONSENT TO TREAT FORM**

NextCare
URGENT CARE

**EXCLUSIVE URGENT CARE
 PARTNER OF THE AIA**

2025-26 CONSENT TO TREAT FORM

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the Arizona Interscholastic Association (AIA), _____
 (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/AIA, to the extent the QMP deems necessary to prevent harm to the student-athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant or nurse practitioner licensed by the state of Arizona (or the state in which the student-athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by Arizona law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designate

PLEASE PRINT LEGIBLY OR TYPE

"I, _____, the undersigned, am the parent/legal guardian of, _____,
 a minor and student-athlete at _____
 (name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by Arizona law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/AIA.

Date: _____ Signature: _____

AIA

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

2025-26

ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

NextCare

URGENT CARE

EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

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

| Medical | Normal | Abnormal |
|-----------------------|--------|----------|
| Appearance | | |
| Eyes/Ears/Throat/Nose | | |
| Hearing | | |
| Lymph Nodes | | |
| Heart | | |
| Murmurs | | |
| Pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary | | |
| Skin | | |

| Musculoskeletal | Normal | Abnormal |
|---------------------|--------|----------|
| Neck | | |
| Back | | |
| Shouler/Arm | | |
| Elbow/Forearm | | |
| Wrist/Hands/Fingers | | |
| Hip/Thigh | | |
| Knee | | |
| Leg/Ankle | | |
| Foot/Toes | | |

A complete PPE requires the information below completed as text or with the official stamp pf the provider's office.

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

NOTES:

Cleared Without Restriction

Cleared With Following Restriction(s): _____

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 Medical Professional (Print/Type): _____ Exam Date: _____

Address: _____ Phone: _____

Signature of Medical Professional: _____, MD/DO/ND/NP/PA-C/CCSP

Medical Professional has reviewed family history _____ (Initials)

FORM 15.7-B 03/27/2025 (rev.) NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.