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

2024-25 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete) Exam Date: _____

Name: _____
Home Address: _____
Phone: _____
Date of Birth: _____
Age: _____
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?	☐	☐
2) List past and current medical conditions: _____		
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____	☐	☐
4) Do you have allergies to medicines, pollens, foods or stinging insects? (Please specify): _____	☐	☐
5) Does your heart race or skip beats during exercise?	☐	☐
6) Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ A Heart Infection		
7) Have you ever had surgery? (Please list): _____	☐	☐
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)	☐	☐
9) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 10):	☐	☐
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):	☐	☐

☐ Head ☐ Neck ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm
☐ Hand/Fingers ☐ Chest ☐ Upper Back ☐ Lower Back ☐ Hip ☐ Thigh
☐ Knee ☐ Calf/Shin ☐ Ankle ☐ Foot/Toes

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

Females Only

	Y	N
37) Have you ever had a menstrual period?	☐	☐
38) How old were you when you had your first menstrual period?	_____	
39) How many periods have you had in the last year?	_____	

Explain "Yes" Answers Here

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?	☐	☐
2)	Has your child ever had extreme shortness of breath during exercise?	☐	☐
3)	Has your child had extreme fatigue associated with exercise (different from other children)?	☐	☐
4)	Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	☐	☐
5)	Has a doctor ever ordered a test for your child's heart?	☐	☐
6)	Has your child ever been diagnosed with an unexplained seizure disorder?	☐	☐
7)	Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	☐	☐

Explain "Yes" Answers Here

COVID-19

		Y	N
1)	Was your child hospitalized as a result for complications of COVID-19?	☐	☐
2)	Has your child had any long-term complications from COVID-19?	☐	☐
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?	☐	☐

Explain "Yes" Answers Here

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

		Y	N
1)	Are there any family members who had sudden/unexpected/unexplained death before age 35? (including SIDS, car accidents drowning or near drowning)	☐	☐
2)	Are there any family members who died suddenly of "heart problems" before age 35?	☐	☐
3)	Are there any family members who have unexplained fainting or seizures?	☐	☐
4)	Are there any relatives with certain conditions, such as:	☐	☐

	Y	N		Y	N
Enlarged Heart	☐	☐	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	☐	☐
Hypertrophic Cardiomyopathy (HCM)	☐	☐	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	☐	☐
Dilated Cardiomyopathy (DCM)	☐	☐	Marfan Syndrome (Aortic Rupture)	☐	☐
Heart Rhythm Problems	☐	☐	Heart Attack, Age 35 or Younger	☐	☐
Long QT Syndrome (LQTS)	☐	☐	Pacemaker or Implanted Defibrillator	☐	☐
Short QT Syndrome	☐	☐	Deaf at Birth	☐	☐
Brugada Syndrome	☐	☐			

Explain "Yes" Answers Here

Additional History

		Y	N
1)	Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?	☐	☐
2)	Do you drink alcohol or use illicit drugs?	☐	☐
3)	Have you ever taken anabolic steroids or used any other performance-enhancing supplements?	☐	☐
4)	Have you ever taken any supplements to help you gain or lose weight, or improve your performance?	☐	☐
5)	Do you always wear a seatbelt while in a vehicle?	☐	☐

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

_____ _____
Signature of MD/DO/ND/NMD/NP/PA-C/CCSP | Date

AIA

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2024-25 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: _____
BP: ____ / ____ (____ / ____,____ / ____)
Vision: R20/____ L20/____ Corrected: Y ☐ N ☐
Pupils: Equal ☐ Unequal ☐

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

* - 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 recommentations 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

FORM 15.7-B rev. 02/08/2024 NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.