ATHLETIC INFORMATION

PVSchools Athletics

2018-2019

NOTE: Physical exam date must be <u>after</u> March 1, 2018.

CHECK ALL THAT APPLY									
BADMINTON		X COUNTRY		SOCCER		SWIM/DIVE		VOLLEYBALL	
BASEBALL		FOOTBALL		SOFTBALL		TENNIS		WRESTLING	
BASKETBALL		GOLF		SPIRITLINE		TRACK		UNIFIED	

OFFICE USE ONLY			
EMERGENCY CARD		CLEARANCE ISSUED	
I C VIDEO		PHYSICAL	
BRAIN BOOK		DATE COMPLETED	

PLEASE READ CAREFULLY AND FULLY COMPLETE ALL PAGES AND SIGNATURE LINES AS THIS FORM HAS BEEN UPDATED

Student Name:	**ID#:**	Birthdate : / /	Gender:	Grade:
Home Address:	City:		Zip:	
Parent Name:	Home Phone :		Cell Phone:	
Guardian Name:	Relationship:		Phone:	
School(s) attended last year:				

IF PARENT OR GURADIAN CANNOT BE REACHED IN AN EMERGENCY, PLEASE CONTACT:

Name:	Home Phone:	Cell Phone:
Primary Physician:		Phone:
Preferred Hospital:	Allergies:	

I hereby give consent for coaches, trainers or a team physician to use their judgement in securing medical aid in emergencies.

<u>INSURANCE:</u> Student Athlete MUST have medical insurance coverage. THE PARADISE VALLEY UNIFIED SCHOOL DISTRICT DOES NOT PROVIDE HEALTH INSURANCE FOR STUDENT ATHLETES. Parents must obtain insurance, as they are responsible for medical bills incurred as a result of participation in athletics. Parents must provide insurance information to assist coaches, trainers, other athletic staff, and medical people in the event an athlete may require medical assistance as a result of injury.

I have purchased school insurance:	**YES**	**NO**	**I have my own insurance:**	**YES**	**NO**
Insurance Company:			**Policy#:**		

<u>BRAINBOOK:</u> ALL athletes are required by the AIA to complete a concussion education course as well as pass a test at the end of the course with a minimum score of 80% before they are allowed to compete in any sport. A certificate of completion must be printed and turned in. The website for this course is http://aiaacademy.org. This course only needs to be completed one time prior to participating in their first District organized athletic sport.

<u>STUDENT ATHLETE DRUG TESTING CONSENT:</u> I/WE HAVE READ AND UNDERSTAND The Paradise Valley Unified School District Parent and Athlete Informed Consent and Random Drug Testing Handbook. I will allow my son/daughter to participate in this drug program while participating as a high-school athlete in the Paradise Valley Unified School District and hereby voluntarily agree to be subject to the terms of the prevention program. I accept the method of obtaining urine samples, testing and analysis of such specimens and all other aspects of the program. I agree to cooperate in furnishing urine specimens that may be required from time to time. I further agree and consent to the disclosure of the sampling, testing, and results as provided in the program. This consent is given pursuant to all state and federal privacy statutes and constitutional and common law privacy provisions and is a waiver of right to nondisclosure of such test records and results, only to the extent of the disclosure authorized in the program.

<u>PERMISSION TO TRANSPORT:</u> I/WE give the District permission for our son/daughter to be transported by District vehicles to away games and off-site practices as required.

<u>EQUIPMENT CODE:</u> It is the athlete's responsibility to care for and return all equipment issued by the high school. I/WE understand and agree that all equipment issued to our son/daughter is the property of the high school and must be returned in reasonable condition. Items lost, stolen, or abused must be replaced and the Athletic Department reimbursed for the cost of the equipment.

<u>CODE OF CONDUCT/HANDBOOK:</u> I/WE have read and understand the information in the Informed Consent Handbook, including the PVUSD statement of understanding and the high school Code of Conduct, and attest the fulfillment of all rules and requirements for athletes, as outlined in the handbook.

ACKNOWLEDGEMENT

<u>RELEASE OF NAME AND /OR IMAGE:</u> I/WE give the District permission for my/our son/daughter to be photographed while participating in District sporting events, and for such photographs to be used in various media publications and formats, including but not limited to web pages, newspaper articles, district publications, and/or district site newsletters. I/WE also agree to allow such photographs to be captioned from time to time with my/our son's/daughters complete name.

PARENT/GUARDIAN SIGNATURE:	**DATE:**

<u>PARENT CONSENT SPORTS INJURY VIDEO:</u> In order to participate in District organized athletics, each student together with their parent or guardian **<u>must view</u>** the online Parent Consent Sports Injury Video prior to participating in their first District organized athletic sport. A link to this video can be found at http://youtu.be/rtTJR9KNVWQ BY SIGNING BELOW, I CONFIRM THAT MY STUDENT ATHLETE AND I HAVE VIEWED THE ONLINE VIDEO AND UNDERSTAND THE RISKS INVOLVED PARTICIPATING IN DISTRICT ATHLETICS.

PARENT/GUARDIAN SIGNATURE:	**DATE:**

I/WE have read, understand and will abide by the statements listed on all pages of this packet.

PARENT/GUARDIAN SIGNATURE:	**DATE:**
STUDENT SIGNATURE:	**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: _____

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 North 18th Stree t, Phoenix, Arizona 85020-5552
Phone: (602) 385-3810

2018-2019 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:
Grade:
School:
Sport(s):
Personal Physician:
Hospital Preference:

In case of emergency, contact:
N a me:
Relationship:
Phone (Home):
(Work):
(Cell):

N a me:
Relationship:
Phone (Home):
(Work):
(Cell):

Explain "Yes" answers on following page.
Circle questions you don't know the answers to.

	Y	N
1) Has a doctor ever denied or restricted your participation in sports for any reason?		
2) Do you have an ongoing medical condition (like diabetes or asthma)?		
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify):		
4) Do you have allergies to medicines, pollens, foods, or stinging insects? (Please specify):		
5) Does your heart race or skip beats during exercise?		
6) Has a doctor ever told you that you have (check all that apply): High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ A Heart Infection ☐		
7) Have you ever spent the night in the hospital?		
8) Have you ever had surgery?		

* 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, circle affected area in the box below):		
*10) Have you had any broken/fractured bones or dislocated joints? (If yes, circle affected area in the box below):		
* 11) Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? (If yes, circle affected area in the box below):		

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

	Y	N
12) Have you ever had a stress fracture?		
13) Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
14) Do you regularly use a brace or assistive device?		
15) Has a doctor told you that you have asthma or allergies?		
16) Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17) Is there anyone in your family who has asthma?		
18) Have you ever used an inhaler or taken asthma medicine?		
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?		
20) Have you had infectious mononucleosis (mono) within the last month?		
21) Do you have any rashes, pressure sores, or other skin problems?		
22) Have you had a herpes skin infection?		
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?		
24) Have you ever had a seizure?		
25) Do you have headaches with exercise?		
26) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?		
27) When exercising in the heat, do you have severe muscle cramps or become ill?		
28) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
29) Have you ever been tested for sickle cell trait?		
30) Have you had any problems with your eyes or vision?		
31) Do you wear glasses or contact lenses?		
32) Do you wear protective eyewear, such as goggles or a face shield?		
33) Are you happy with your weight?		
34) Are you trying to gain or lose weight?		
35) Has anyone recommended you change your weight or eating habits?		
36) Do you limit or carefully control what you eat?		
37) Do you have any concerns that you would like to discuss with a doctor?		

Females Only

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

Explain "Yes" Answers Here

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2018-2019 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Physician should fill out this form with assistance from the Parent or Guardian.)

Student Name: | Date of Birth:

Patient History Questions: Please tell me about your child...

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

Family History Questions: Please tell me about any of the following in your family...

	Y	N
8) Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accidents, drowning, or near drowning)		
9) Are there any family members who died suddenly of "heart problems" before age 50?		
10) Are there any family members who have unexplained fainting or seizures?		
11) Are there any relatives with certain conditions, such as:		

	Y	N
Enlarged Heart		
Hypertrophic Cardiomyopathy (HCM)		
Dilated Cardiomyopathy (DCM)		
Heart Rhythm problems:		
Long QT Syndrome (LQTS)		
Short QT Syndrome		
Brugada Syndrome		
Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)		
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)		
Marfan Syndrome (Aortic Rupture)		
Heart Attack, age 50 or younger		
Pacemaker or Implanted Defibrillator		
Deaf at Birth (Congenital Deafness)		

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of athlete | Signature of parent/guardian | Date

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

NextCare is the preferred partner of the AIA, it is not required you visit NextCare locations for your healthcare needs.

ARIZONAINTERSCHOLASTICASSOCIATION
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Phone: (602) 385-3810

2018-2019 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

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/Hand/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
☐ Not Cleared For: ☐ All Sports ☐ Certain Sports _____ ☐ Reason: _____
Recommendations: _____

Name of Physician(Print/Type): _____ Exam Date: _____

Address: _____ Phone: _____

Signature of Physician: _____, MD/DO/NP/PA-C

FORM 15.7-B 03/12

PVSchools Athletics

Select Medical Corporation

NORTH CANYON | PINNACLE | HORIZON | SHADOW MOUNTAIN | PARADISE VALLEY

ATHLETICS CONSENT FOR EMERGENCY CARE/TREATMENT

Student Name:		
Date of Birth: / /	Student ID #:	Grade:
Fall Sport(s):	Winter Sport(s):	Spring Sport(s):

In the event that an athletic injury or illness should occur to the above named student athlete while participating in a sanctioned athletic activity at a Paradise Valley Unified School District site, I give my permission for them to receive proper/necessary care from a certified/licensed athletic trainer, physician or other health care individual representing Select Medical Outpatient Division. Furthermore, in the event that a medical emergency should occur and I cannot be contacted, I give my permission for a Select Medical health representative to arrange for ambulance service to the nearest medical facility. I also give permission for the staff of the medical facility to render treatment, which is considered necessary for the student-athletes wellbeing and health.

Parent or Guardian Name:		
Mailing Address:		
Father's Phone Numbers:	**Primary:**	**Secondary:**
Mother's Phone Numbers:	**Primary:**	**Secondary:**
IN CASE OF EMERGENCY AND PARENT/GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:		
Friend/Relative Name:		**Phone:**
Friend/Relative Name:		**Phone:**
Family Physician:		**Phone:**
Hospital:		
Insurance Company:		**Policy Number:**
PLEASE LIST ANY MEDICAL CONDITIONS/MEDICATIONS/ALLERGIES BELOW:		

I have carefully read this agreement and I fully understand its contents and I sign of my own free will.

Parent/Guardian Signature: _____ Date: _____