Exam Date _____

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

2014-2015 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

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

Name _____ Sex _____ Age _____ Date of Birth _____ Grade _____

School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____ Hospital Preference _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H): _____ (W): _____ (C) _____

Name _____ Relationship _____ Phone (H): _____ (W): _____ (C) _____

Explain "Yes" answers below.
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?	□	□
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 boxes 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 boxes below):***	□	□
* □ Head □ Neck □ Shoulder □ Upper Arm □ Elbow □ Forearm □ Hand/Fingers □ Chest □ Upper Back □ Low Back □ Hip □ Thigh □ Knee □ Calf/Shin □ Ankle □ Foot/Toes		
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 inyour family who has asthma?	□	□

	YES	NO
18) Have you ever used an inhaler or taken asthma medici	□	□
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) Doyou 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 mucsle 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

	YES	NO
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:

AIA ARIZONA INTERSCHOLASTIC ASSOCIATION

OUR STUDENTS, OUR TEAMS . . . OUR FUTURE.

2014-2015 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....	**YES**	**NO**
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 exercised -induced asthma not well controlled with medication?	□	□
Family History Questions: Please tell me about any of the following in your family....	**YES**	**NO**
8) Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accidents, drowning, or near drowning)	□	□
9) Are there any family members who died suddenly of "heart problems" before age 50?	□	□
10) Are there any family members who have unexplained fainting or seizures?	□	□
11) Are there any relatives with certain conditions, such as:		
Enlarged Heart:	□	□
Hypertrophic Cardiomyopathy (HCM)	□	□
Dilated Cardiomyopathy (DCM)	□	□
Heart Rhythm problems:	□	□
Long QT Syndrome (LQTS)	□	□
Short QT Syndrome	□	□
Brugada Syndrome	□	□
Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	□	□
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	□	□
Marfan Syndrome (Aortic Rupture)	□	□
Heart Attack, age 50 or younger	□	□
Pacemaker or Implanted Defibrillator	□	□
Deaf at Birth (Congenital Deafness)	□	□

Explain "Yes" answers here:

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

Signature of athlete: _____ Signature of parent/guardian: _____ Date: _____

Signature of Physician: _____ Date: _____

FORM 15.7-A 02/14