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?	☐	☐
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

	Yes	No
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) Have you or someone in your family tested positive for sickle cell trait or sickle cell disease?	☐	☐
27) Have you been hospitalized or had long-term complication care due to COVID-19?	☐	☐
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

	Yes	No
33) Have you ever had a menstrual period?	☐	☐
34) How old were you when you had your first menstrual period?	_____	
35) How many periods have you had in the last year?	_____	

Explain "Yes" Answers Here

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?	☐	☐
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

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

		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)	☐	☐
2)	Are there any family members who died suddenly of "heart problems" before age 50?	☐	☐
3)	Are there any family members who have unexplained fainting or seizures?	☐	☐
4)	Are there any relatives with certain conditions, such as:		

	Yes	No		Yes	No
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 50 or Younger	☐	☐
Long QT Syndrome (LQTS)	☐	☐	Pacemaker or Implanted Defibrillator	☐	☐
Short QT Syndrome	☐	☐	Deaf at Birth	☐	☐
Brugada Syndrome	☐	☐			

Explain "Yes" Answers Here

Additional History

		Yes	No
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 _____

AIA

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

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 recommentations 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.