



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

**2025-26**  
**ANNUAL PREPARTICIPATION**  
**PHYSICAL EVALUATION**



**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:<br>_____  |           |            |            |           |         |         |              |       |            |            |     |       |      |           |       |           |  |  |  |  |
| 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?<br>(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):<br><div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>High Blood Pressure</span> <span>A Heart Murmur</span> <span>High Cholesterol</span> <span>A Heart Infection</span> </div>   |           |            |            |           |         |         |              |       |            |            |     |       |      |           |       |           |  |  |  |  |
| 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?<br>(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):   |           |            |            |           |         |         |              |       |            |            |     |       |      |           |       |           |  |  |  |  |
| <table border="0" style="width: 100%; text-align: center;"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper Arm</td> <td>Elbow</td> <td>Forearm</td> </tr> <tr> <td>Hand/Fingers</td> <td>Chest</td> <td>Upper Back</td> <td>Lower Back</td> <td>Hip</td> <td>Thigh</td> </tr> <tr> <td>Knee</td> <td>Calf/Shin</td> <td>Ankle</td> <td>Foot/Toes</td> <td></td> <td></td> </tr> </table> | Head      | Neck       | Shoulder   | Upper Arm | Elbow   | Forearm | Hand/Fingers | Chest | Upper Back | Lower Back | Hip | Thigh | Knee | Calf/Shin | Ankle | Foot/Toes |  |  |  |  |
| 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**

**Explain "Yes" Answers Here**

|  | 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?            |     | _____ |



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**EXCLUSIVE URGENT CARE**  
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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**

|   | <b>Yes</b> | <b>No</b> |
|---|------------|-----------|
| 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**

For more information regarding student-athlete mental health:

[Quiet Suffering - A Resource for Student-Athlete Mental Health](https://spark.adobe.com/page/lltwyoLpTAp0V/)

[spark.adobe.com/page/lltwyoLpTAp0V/](https://spark.adobe.com/page/lltwyoLpTAp0V/)

Teen Lifeline Call and Text Crisis Line

(602) 248-8336 (TEEN)

Outside Maricopa county call: 1-800-248-8336 (TEEN)

Hours are: Call 24/7/365 | Text weekdays 12-9 p.m. & weekends 3-9 p.m. | Peer counseling 3-9 p.m. daily

Crisis text line: Text HOME to 741741 to connect with a crisis counselor

National Suicide Prevention Lifeline

1-800-273-8255 or [suicidepreventionlifeline.org](https://suicidepreventionlifeline.org)

The Trevor Lifeline

866-488-7386 (for gender diverse youth)



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_  
**BMI:** \_\_\_\_\_ **BMI %tile:** \_\_\_\_\_ BP: \_\_\_\_ / \_\_\_\_ (\_\_\_\_ / \_\_\_\_, \_\_\_\_ / \_\_\_\_)  
 Vision: R20/\_\_\_\_ L20/\_\_\_\_ Corrected: Y N  
 Pupils: Equal Unequal **SBP %tile:** \_\_\_\_\_ **DBP %tile:** \_\_\_\_\_

|                        | Normal | Abnormal Findings | Initials * |
|------------------------|--------|-------------------|------------|
| <b>Medical</b>         |        |                   |            |
| Appearance             |        |                   |            |
| Eyes/Ears/Throat/Nose  |        |                   |            |
| Hearing                |        |                   |            |
| Lymph Nodes            |        |                   |            |
| Heart                  |        |                   |            |
| Murmurs                |        |                   |            |
| Pulses                 |        |                   |            |
| Lungs                  |        |                   |            |
| Abdomen                |        |                   |            |
| Genitourinary &        |        |                   |            |
| Skin                   |        |                   |            |
| <b>Musculoskeletal</b> |        |                   |            |
| 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 recommendations 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

## 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: \_\_\_\_\_



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**2025-26**

**CONSENT TO TREAT FORM**



**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

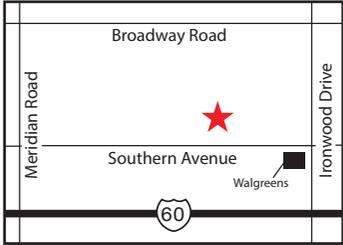
**PLEASE PRINT LEGIBLY OR TYPE**

"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.

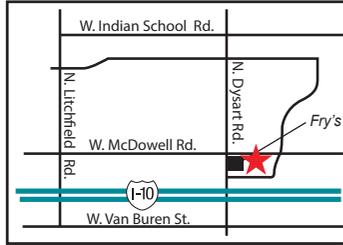
I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities 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.

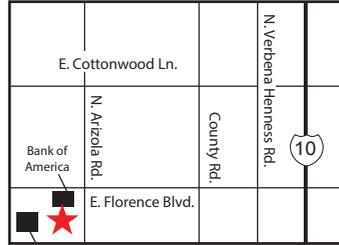
Date: \_\_\_\_\_ Signature: \_\_\_\_\_



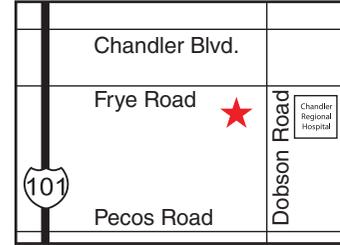
**Apache Junction • 85120**  
2080 West Southern Ave., Suite #A1



**Avondale • 85392**  
13075 W. McDowell Rd., Suite #D106



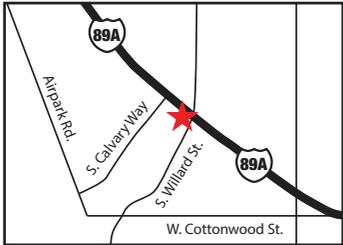
**Casa Grande • 85122**  
1683 E. Florence Blvd., Suite #7



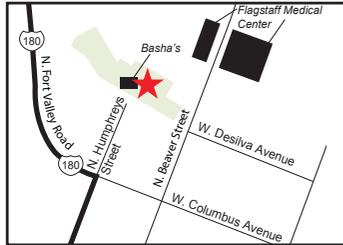
**Chandler • 85224**  
600 S. Dobson Road, Suite #C-26



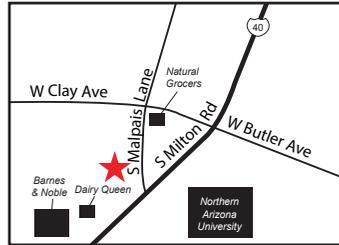
**Chandler • 85248**  
1155 W. Ocotillo Road, Suite #4



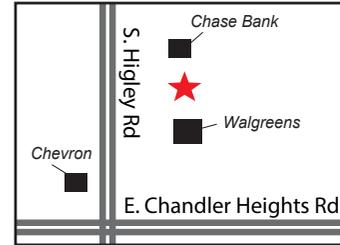
**Cottonwood • 86326**  
450 S. Willard Street, Suite #120



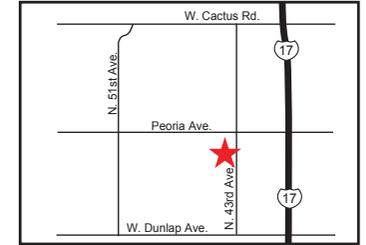
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1000 N. Humphreys St., Suite #104



**Flagstaff • 86001**  
399 S. Malpais Lane, Suite #100



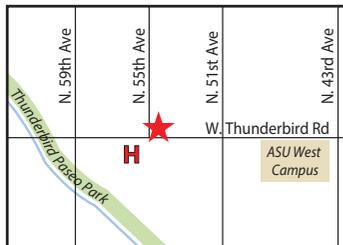
**Gilbert • 85298**  
6343 S. Higley Road



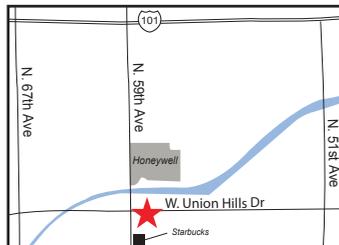
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**Glendale • 85305**  
9494 W. Northern Ave., Suite #101



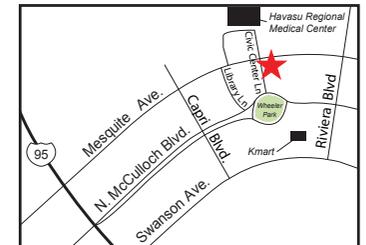
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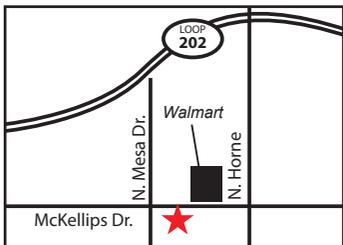
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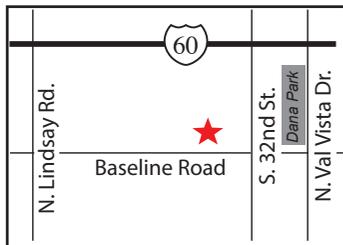
**Goodyear • 85338**  
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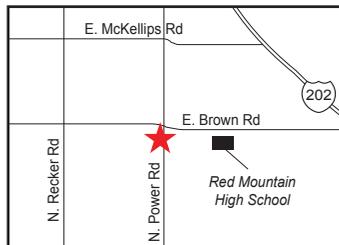
**Lake Havasu City • 86403**  
1810 Mesquite Ave., Suite B



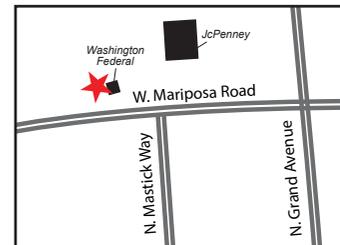
**Mesa • 85203**  
535 E. Mckellips Road, Suite #101



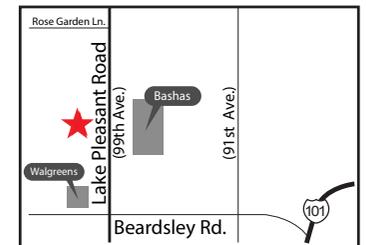
**Mesa • 85204**  
3130 E. Baseline Road, Suite #105



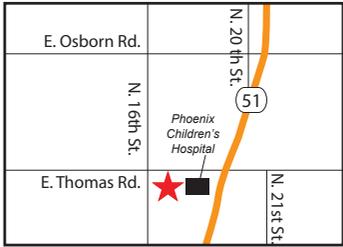
**Mesa • 85205**  
1066 N. Power Road, Suite #101



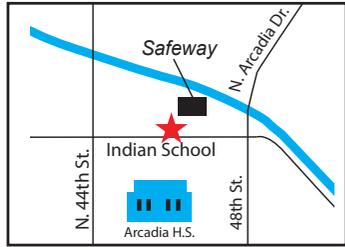
**Nogales • 85621**  
298 W. Mariposa Road



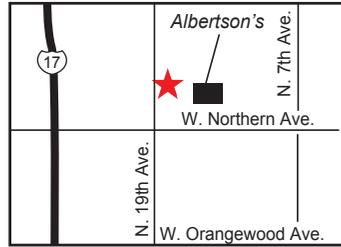
**Peoria • 85382**  
20470 N. Lake Pleasant Rd., Suite #102



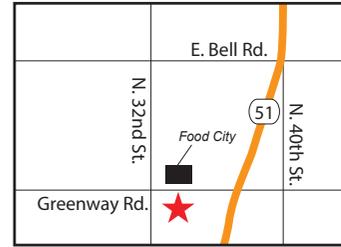
**Phoenix • 85016**  
1701 E. Thomas Road, Suite #A104



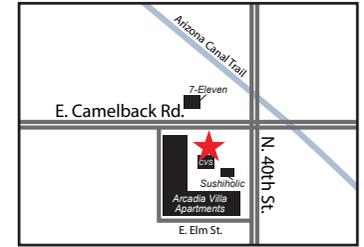
**Phoenix • 85018**  
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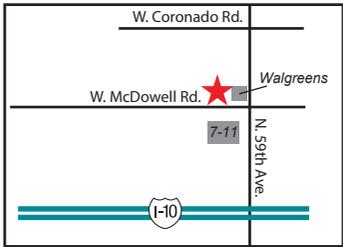
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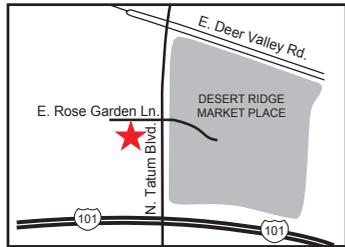
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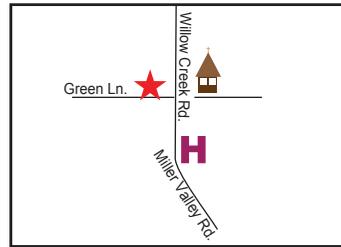
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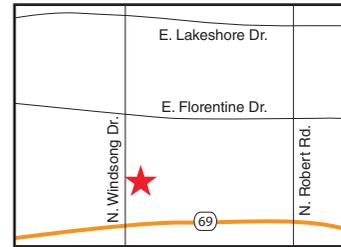
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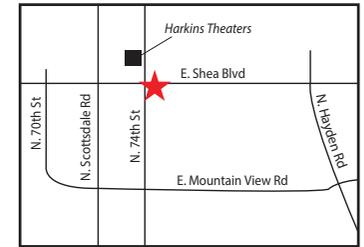
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20950 N. Tatum Blvd., Suite #190



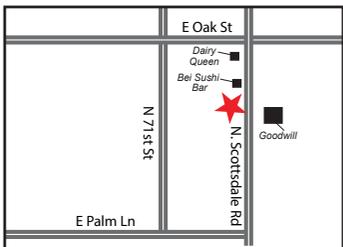
**Prescott • 86301**  
2062 Willow Creek Road



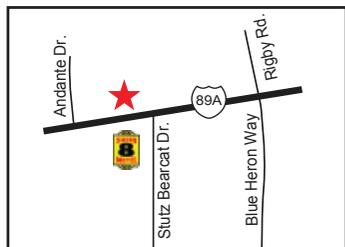
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3051 N. Windsong Drive



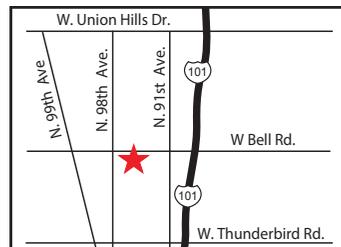
**Scottsdale • 85260**  
7425 E. Shea Blvd., Suite #108



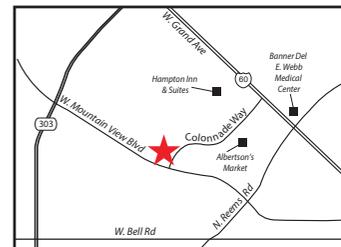
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2122 N. Scottsdale Road



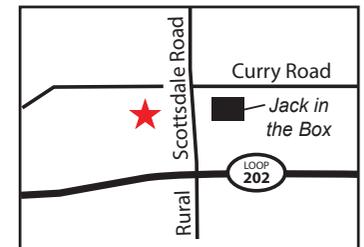
**Sedona • 86336**  
2530 W. SR 89A, Suite #A



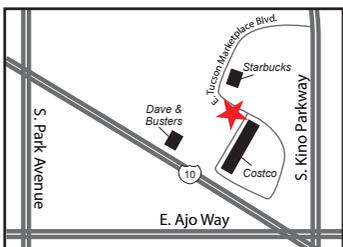
**Sun City • 85351**  
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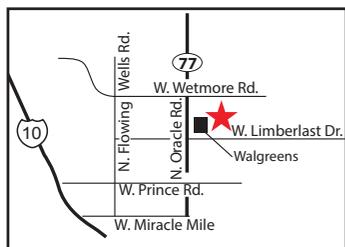
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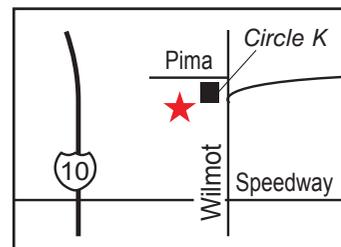
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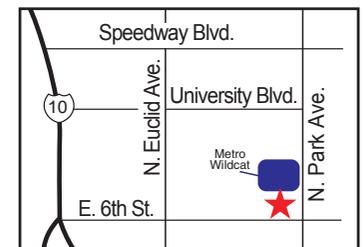
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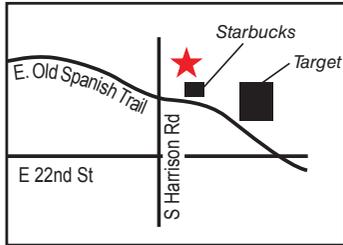
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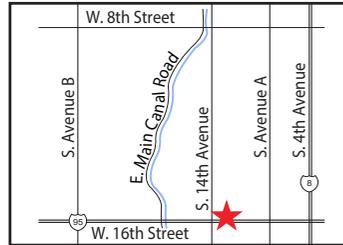
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