2026-2027 Athletic Packet for Desert Mountain

To tryout or participate in any of our sports you will need to have the following completed before tryouts or cross country practice. Please upload all documents to Register My Athlete (RMA), ***When uploading physicals please upload all of the pages to Register My Athlete.***

_____**Completed Physical:** Physicals must be from a doctor and uploaded to RMA. Physicals are good for one calendar year.

_____**Register your athlete on RMA:** Complete all sections of RMA and Mr. Booth will approve registration.

_____**Completed Physical:** Physicals must be from a doctor and uploaded to RMA. Physicals are good for one calendar year.

_____**Brainbook Course**: Directions are attached or you can find them on RMA under the Brainbook section. Upload certificate onto RMA. This only has to be done once, the certificate will stay in the athletes registration.

_____**Emergency Contact Form:** The form is attached or itcan be downloaded from RMA, complete the form and upload it to RMA. This is separate from the physical.

AIA
ARIZONA INTERSCHOLASTIC ASSOC.
OUR STUDENTS, OUR TEAMS ... OUR FUTURE

2026-27 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

Banner 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 Phone:
Address: _____ 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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OUR STUDENTS, OUR TEAMS ... OUR FUTURE

2026-27 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

Banner Urgent Care
EXCLUSIVE URGENT CARE PARTNER OF THE AIA

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 _____

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2026-27 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Banner Urgent Care
EXCLUSIVE URGENT CARE PARTNER OF THE AIA

Name: _____ Date of Birth: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ % Body Fat (optional): _____

Pulse: _____ Blood Pressure (1st measure): ____ / ____ (2nd measure) ____ / ____ (3rd measure) ____ / ____

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	A bnor mal
Neck		
Back		
Shoulder/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-examinerset-uponly|& - Having a third party present is recommended for the genitourinary examination

NOTES AND RECOMMENDATIONS:

☐ Cleared without restriction for all sports

☐ Cleared with the following restrictions and/or recommendations: _____

_____ Not cleared for

☐ any sports [Reason(s)]: _____

_____

Medical Professional has reviewed family history _____ (Initials) Exam Date: _____

Name of Medical Professional (Print/Type): _____ Address:

_____

_____ Phone:

_____ Signature of Medical

Professional: _____ Medical Credential (Circle): MD / DO / ND / NP / PA-C / CCSP

FORM 15.7-B 02/25/2026 (rev.) Banner Urgent Care is the preferred partner of the AIA. It is not required you visit Banner locations for your healthcare needs.

2026-27 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: _____

AIA ARIZONA INTERSCHOLASTIC ASSOCIATION™

OUR STUDENTS, OUR TEAMS . . . OUR FUTURE.

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.

Bysigningbelow, 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: _____

D.V.U.S.D.ATHLETIC EMERGENCY INFORMATION FORM

NVMLC & DVCC 7-8

CHECK ALL THAT APPLY

- ☐ Spiritline
- ☐ Volleyball
- ☐ Basketball
- ☐ X Country
- ☐ Wrestling
- ☐ Baseball
- ☐ Softball
- ☐ Track

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

STUDENT:_____ STUDENT ID: _____ DATE OF BIRTH:_____ SEX:_____ GRADE _____

HOME ADDRESS:_____ CITY:_____ ZIP:_____

Father/Legal Guardian Name: _____ Mother/Legal Guardian Name: _____

Home/Cell Phone:_____ Home/Cell Phone: _____

School or schools attended last year: _____

IF PARENT OR GUARDIAN CANNOT BE CONTACTED IN AN EMERGENCY, PLEASE CONTACT:

NAME:_____ HOME PHONE:_____ CELL PHONE:_____

PHYSICIAN:_____ PHYSICIAN'S PHONE: _____

PREFERRED HOSPITAL: _____ ALLERGIES: _____

PLEASE INITIAL AND COMPLETE EACH SECTION BELOW

_____ **MEDICIAL TREATMENT/ASSISTANCE**

I hereby give consent for coaches, trainers, or a team physician to use their judgment in securing medical treatment/assistance in emergencies.

_____ **INSURANCE**

Student athlete must have medical insurance coverage. THE DEER 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 personnel 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 Co: _____ **Policy No.:** _____

_____ **BRAINBOOK**

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

_____ **PERMISSION TO TRANSPORT**

I/WE give my permission to participate in interscholastic activities and to travel with the team as a member using school approved transportation.

_____ **EQUIPMENT CODE**

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 **middle 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.

_____ **Family and Coach Agreement**

I/We have read and understand the DVUSD Policy regarding the Family and Coach Agreement

_____ **PURSUING VICTORY WITH HONOR** (Located in Parent/Athlete Handbook)

I/WE have read and understand my/our responsibility regarding my behavior as set forth in on the Pursuing Victory with Honor Code of Conduct forms for parents and athletes.

ACKNOWLEDGEMENT

RELEASE OF NAME AND/OR IMAGE

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 newsletter. I/WE also agree to allow such photographs to be captioned from time to time with my/our son/daughter's full name.

PARENT/GUARDIAN SIGNATURE: _____

INFORMED CONSENT SPORTS INJURY VIDEO

In order to participate in District organized athletics, each student together with their parent or guardian **must view** the online Informed Consent Sports Injury video prior to participating in their first District organized athletic sport. A link to this video can be found at http://www.dvusd.org/Page/11429. By my signature below, I confirm that my student athlete and I have viewed the online video and understand the risks involved in participation in District Athletics.

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

I/WE have read, understand, and will abide by the statements listed separately and included in the Parent/Athlete Handbook found at http://www.dvusd.org/Domain/1301

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

STUDENT SIGNATURE: _____ **DATE:**_____

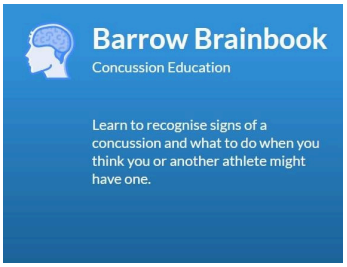
DEER VALLEY Unified School District

Brainbook Concussion Course Completion Certificate

A Brainbook Concussion certificate must be on file at the school. This is an online course that must be completed prior to any participation. Directions for taking the course can be found at the address below. This course only needs to be completed once. (Any 8th graders that turned in their certificates during 7th grade, do not have to take the course again.)

Directions for completing the course.

1. Go to http://aiaacademy.org/
2. Select Concussion - Brainbook picture shown below.



3. Register as a student
4. Enter Demographic Information:
    -Be sure to select a username and password that you will remember
    -Enter the name of the high school you'll be attending as a 9th grader
    -Enter 9th grade
    -Select the sport that you are participating in this season.
5. Select "Register" at the bottom of the page
6. Log in and complete the course
7. Print the certificate and upload it to Register My Athlete under the Brainbucket section.