ATHLETIC INFORMATION

PVSchools Athletics

2019-2020

NOTE: Physical exam date must be <u>after</u> March 1, 2019.

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
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
PHONE: (602) 385-3810

2019-20 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: _____
Gender: _____
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.

	Y	N
1) Has a doctor ever denied or restricted your participation in sports for any reason?		
2) Do you have an ongoing medical conditional (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 stringing 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 a 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, check affected area in the box below in question 11)		
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11)		
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, 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		

	Y	N
12) Have you ever had a stress fracture?		
13) Have you ever 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 medication?		
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?		
26) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?		
27) While 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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2019-20 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

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 drowing 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		Y	N
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

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

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2019-20 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/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: _____
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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2019-20 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 designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

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: _____

PVSchools Athletics

Banner Physical Therapy & Rehabilitation
In partnership with Select Medical

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 Banner Physical Therapy Outpatient Division. Furthermore, in the event that a medical emergency should occur and I cannot be contacted, I give my permission for a Banner Physical Therapy 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: _____