



## ARIZONA INTERSCHOLASTIC ASSOCIATION

7007 North 18th Street, Phoenix, Arizona 85020-5552

Phone: (602) 385-3810

**2012-2013 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		YES	NO			
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>			
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify):	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>			
4. Do you have allergies to medicines, pollens, foods, or stinging insects? (Please specify):	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without, are you missing. Or do you have a nonfunctioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. 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")?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Has a doctor ever told you that you have (check all that apply):	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	33. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>			
10. Has a doctor ever ordered a test for your heart? (ex: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	35. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	36. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	37. Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>			
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	38. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	39. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	41. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>			
17. 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 boxes below:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>			
18. Have you had any broken/fractured bones or dislocated joints? If yes, circle affected area in the boxes below:	<input type="checkbox"/>	<input type="checkbox"/>	43. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>			
19. 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:	<input type="checkbox"/>	<input type="checkbox"/>	44. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm	<b>FEMALES ONLY</b>							
<input type="checkbox"/> Hand/Fingers <input type="checkbox"/> Chest <input type="checkbox"/> Upper Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> Thigh						45. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee <input type="checkbox"/> Calf/Shin <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/Toes						46. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	47. How old were you when you had your first menstrual period?	_____				
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	48. How many periods have you had in the last year?	_____				
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here: _____ _____ _____					
23. Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>						

I hereby state that, to the best of my knowledge, my answers to 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