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.

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 sig Print Name:	n name below and indicate date signed: _ Signature:	Date:



(The	parent or guardian should	fill out this form with	assistance from the stu	udent-athle	te) E	xam Date:	
Nar	ne:				In case of	emergency conta	ct:
Home Address:					Name:		
	ne:					iip:	
	e of Birth:						
Age	:					ome):	
	ıder:				•	ork):	
	de:				Phone (Ce	ell):	
	ool:				Name: _		
	rt(s):				Relationsh	iip:	
	onal Physician: pital Preference:				Phone (Ho	ome):	
					Phone (W	ork):	
Exp	lain "Yes" answers on th	ne following page.				əll):	
	le questions you don't k			l	•		
4) 5) 6)	Do you have an ongoin Are you currently taking supplements? (Please sp Do you have allergies to (Please specify): Does your heart race or Has a doctor ever told y High Blood Pressure Have you ever spent the	g any prescription of becify): o medicines, pollen skip beats during you that you have (A Heart Murmu	or nonprescription (c s, foods or stringing exercise? check all that apply or High Choles	insects?	ounter) me		_
8)	Have you ever had surg						
	Have you ever had an i you to miss a practice o	njury (sprain, musc					
10)	Have you had any brok (If yes, check affected c			ŚŚ			
11)	Have you had a bone/j physical therapy, a brac		•	•	•		
	Head	Neck	Shoulder	Uppe	r Arm	Elbow	Forearm
	Hand/Fingers	Chest	Upper Back	Lowe	r Back	Hip	Thigh
	Knee	Calf/Shin	Ankle	Foot/	Toes		



ARIZONA INTERSCHOLASTIC ASSOC.

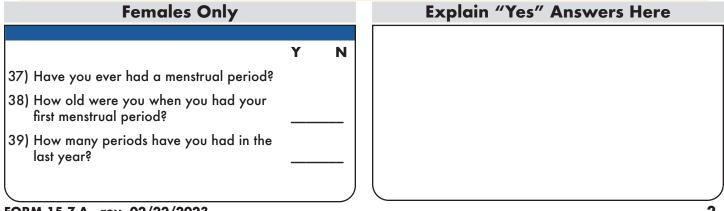
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ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

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- 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 non-functioning 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?
- 25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?
- 26) While exercising in the heat, do you have severe muscle cramps or become ill?
- 27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
- 28) Have you ever been tested for sickle cell trait?
- 29) Have you had any problems with your eyes or vision?
- 30) Do you wear glasses or contact lenses?
- 31) Do you wear protective eyewear, such as goggles or a face shield?
- 32) Are you happy with your weight?
- 33) Are you trying to gain or lose weight?
- 34) Has anyone recommended you change your weight or eating habits?
- 35) Do you limit or carefully control what you eat?
- 36) Do you have any concerns that you would like to discuss with a doctor?





2023-24 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: ____

Date of Birth: _____

Y

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Patient History Questions: Please Tell Me About Your Child...

- 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

COVID-19...

		Y	Ν
1)	Has your child been diagnosed with COVID-19?		
	1a) If yes, is your child still having symptoms from their COVID-19 infection?		
2)	Was your child hospitalized as a result for complications of COVID-19?		
3)	Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)?		
4)	Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist)		
	to be cleared to return to sports?		
5)	Has your child returned back to full participation in sports?		
6)	Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?		
	6a) Was your child tested for COVID-19?		
7)	Did your child receive the COVID-19 vaccine?		
	7a) What was the manufacturer of the vaccine?		
	7b) Date of vaccination(s)		

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	

(A sum of \geq 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

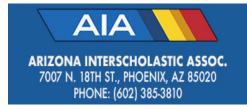
If you score a sum of 3 or greater on either questions 1 and 2, or 3 and 4, you may have anxiety or depression that is affecting you more than normal. In this case, it is recommended that you talk to a trusted health care provider such as your primary care physician, your athletic trainer at school, or a counselor at school. If there is not someone you feel comfortable talking to or you are interested in learning more to help yourself or a friend, please use the resources provided below.

For more information regarding student-athlete mental health: <u>Quiet Suffering - A Resource for Student-Athlete Mental Health</u> spark.adobe.com/page/ILtwyoLpTApOV/

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

The Trevor Lifeline 866-488-7386 (for gender diverse youth)



2023-24 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

Family History Questions: Please Tell Me About Any Of The Following In Your Family...

			Y	Ν	
1)	 Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowning or near drowning) 				
2)	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: 				
	Y N		Y	Ν	
	Enlarged Heart Catechola	ninergic Polymorphic Ventricular Tachycardia (CPVT)			
	Hypertrophic Cardiomyopathy (HCM) Arrhythmo	genic Right Ventricular Cardiomyopathy (ARVC)			
	Dilated Cardiomyopathy (DCM) Marfan Sy	ndrome (Aortic Rupture)			
	Heart Rhythm Problems Heart Atta	ck, Age 50 or Younger			
	Long QT Syndrome (LQTS) Pacemaker	or Implanted Defibrillator			
	Short QT Syndrome Deaf at Bir	th			
	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 Student-Athlete

Signature of Parent/Guardian

Date

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP

Date



7007 N. 18TH ST., PHOENIX, AZ 85020 PHONE: (602) 385-3810 2023-24 ANNUAL PREPARTICIPATION

PHYSICAL EXAMINATION

Name			Date of Birth:	
			Date of binn	
-			0eX Weight:	
			Pulse:	
	(op.ional)		BP: / (/ /)	
Vision:	R20/	_ L20/_		
Pupils:	Equal	Unequ	al	
		Normal	Abnormal Findings	Initials *
Medical				
Appearance				
Eyes/Ears/Th	nroat/Nose			
Hearing				
Lymph Node	S			
Heart				
Murmurs				
Pulses				
Lungs				
Abdomen				
Genitourinar	у &			
Skin				
Musculos	keletal			
Neck				
Back				
Shoulder/Ar	m			
Elbow/Fored	ırm			
Wrist/Hands	/Fingers			
Hip/Thigh				
Knee				
Leg/Ankle				
Foot/Toes				
	* - Multi-exami	ner set-up only	& - Having a third party present is recommended for the genitourinary examination	
NOTES:				
Cleared With	out Restriction			
		triction		
Not Cleared F	•		ain Sports: Reason:	
		or all sports wi	ithout restriction with recommentations for further evaluation or treatment of	
	- ~	•	· · ·	
Recommendat	ions:			
Name of Phys	ician (Print/T∨	pe):	Exam Date:	
-	-	-	Phone:	
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FORM 15.7-B 02/22/2023 (rev.)