Exam Date _____

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 North 18th Street, Phoenix, Arizona 85020-5552
Phone: (602) 385-3810

2011-2012 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
1. Has a doctor ever denied or restricted your participation in sports for any reason?	□	□
2. Do you have an ongoing medical condition (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 stinging insects? (Please specify): _____	□	□
5. Have you ever passed out or nearly passed our DURING exercise?	□	□
6. Have you ever passed out or nearly passed out AFTER exercise?	□	□
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	□	□
8. Does your heart race or skip beats during exercise?	□	□
9. Has a doctor ever told you that you have (check all that apply): □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection	□	□
10. Has a doctor ever ordered a test for your heart? (ex: ECG, echocardiogram)	□	□
11. Has anyone in your family died for no apparent reason?	□	□
12. Does anyone in your family have a heart problem?	□	□
13. Has any family member or relative died of heart problems or of sudden death before age 50?	□	□
14. Does anyone in your family have Marfan syndrome?	□	□
15. Have you ever spent the night in the hospital?	□	□
16. Have you ever had surgery?	□	□
* 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.	□	□
* 18. Have you had any broken/fractured bones or dislocated joints? If yes, circle affected area in the boxes below.	□	□
* 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.	□	□
* □ Head □ Neck □ Shoulder □ Upper Arm □ Elbow □ Forearm □ Hand/Fingers □ Chest □ Upper Back □ Low Back □ Hip □ Thigh □ Knee □ Calf/Shin □ Ankle □ Foot/Toes		
20. Have you ever had a stress fracture?	□	□
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	□	□
22. Do you regularly use a brace or assistive device?	□	□
23. Has a doctor told you that you have asthma or allergies?	□	□

	YES	NO
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	□	□
25. Is there anyone in your family who has asthma?	□	□
26. Have you ever used an inhaler or taken asthma medicine?	□	□
27. Were you born without, are you missing. Or do you have a nonfunctioning kidney, eye, testicle or any other organ?	□	□
28. Have you had infectious mononucleosis (mono) within the last month?	□	□
29. Do you have any rashes, pressure sores, or other skin problems?	□	□
30. Have you had a herpes skin infection?	□	□
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")?	□	□
32. Have you ever had a seizure?	□	□
33. Doyou have headaches with exercise?	□	□
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?	□	□
35. When exercising in the heat, do you have severe muscle cramps or become ill?	□	□
36. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	□	□
37. Have you ever been tested for sickle cell trait?	□	□
38. Have you had any problems with your eyes or vision?	□	□
39. Do you wear glasses or contact lenses?	□	□
40. Do you wear protective eyewear, such as goggles or a face shield?	□	□
41. Are you happy with your weight?	□	□
42. Are you trying to gain or lose weight?	□	□
43. Has anyone recommended you change your weight or eating habits?	□	□
44. Do you limit or carefully control what you eat?	□	□
45. Do you have any concerns that you would like to discuss with a doctor?	□	□

FEMALES ONLY

46. Have you ever had a menstrual period?	□	□
47. How old were you when you had your first menstrual period?		
48. How many periods have you had in the last year?		

Explain "Yes" answers here:

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