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

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** _____

Address _____ **Phone** _____

In case of emergency, contact: **Name:** _____

Explain "Yes" answers below.
Circle questions you don't know the answer to.

Phone (H): _____ **(W)** _____

Cell Phone: _____

	Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
Are you currently being treated for an injury or condition?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies to medications? _____	☐	☐
Do you have any allergies to pollen, food or stinging insects?	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month?	☐	☐
Has a doctor ever denied or restricted your participation in sports for any heart problems?	☐	☐
Has anyone in your immediate family had the following conditions?	☐	☐
Diabetes ☐ Heart disease ☐ other ☐		
Sudden death prior to age 50 ☐ High Blood Pressure ☐		
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐

	Yes	No
9. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you use an inhaler?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? _____	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. Have you ever had a sprain, strain, or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

13. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14. Do you feel stressed?	☐	☐
15. Do you or have you ever used:	☐	☐

Smokeless tobacco ☐ Cigarettes ☐
Alcohol ☐ Recreational drugs ☐

Females Only

16. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

Explanation: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for athletic participation.
I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

_____ _____ _____
Signature of Parent/Guardian **Signature of Student Athlete** **Date**

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ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

ANNUAL PHYSICAL EXAMINATION

Name: _____ **Date:** _____

Height: _____ **Weight:** _____ **Pulse:** _____ **BP:** _____

Vision: R 20/ _____ **L 20/** _____ **Glasses/Contacts: Yes** ☐ **No** ☐ **Pupils: Equal** ☐ **Unequal** ☐

	Normal	Abnormal Findings	Initials*
Medical			
Appearance	☐		
Skin	☐		
Eyes/Ears/Nose	☐		
Throat/ Oropharynx	☐		
Lymph Nodes	☐		
Heart	☐		
Pulses	☐		
Lungs	☐		
Abdomen	☐		
Genitalia/ Hernia	☐		
Musculoskeletal			
Neck	☐		
Back	☐		
Shoulder/arm	☐		
Elbow/forearm	☐		
Wrist/hand	☐		
Hip/thigh	☐		
Knee	☐		
Leg/ankle	☐		
Foot	☐		

*Station-based examination only

CLEARANCE

☐ **Cleared**

☐ **Cleared after completing evaluation/rehabilitation for:** _____

_____

_____

☐ **Not Cleared for:** _____ **Reason:** _____

Recommendations: _____

_____

Name of Physician (print/type) _____ **Date** _____

Address _____ **Phone** _____

Signature of Physician _____ **MD/DO/NP/PA-C**