



### 2018-2019 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:  
Sex:  
Grade:  
School:  
Sport(s):  
Personal Physician:  
Hospital Preference:

In case of emergency, contact:  
Name:  
Relationship:  
Phone (Home):  
(Work):  
(Cell):

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Name:  
Relationship:  
Phone (Home):  
(Work):  
(Cell):

Explain "Yes" answers on 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?                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Do you have an ongoing medical condition (like diabetes or asthma)?                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements?<br>(Please specify):                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Do you have allergies to medicines, pollens, foods, or stinging insects?<br>(Please specify):                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Does your heart race or skip beats during exercise?                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Has a doctor ever told you that you have (check all that apply):<br>High Blood Pressure      A Heart Murmur      High Cholesterol      A Heart Infection                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Have you ever spent the night in the hospital?                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Have you ever had surgery?                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| * 9) 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 box below):                             | <input type="checkbox"/> | <input type="checkbox"/> |
| *10) Have you had any broken/fractured bones or dislocated joints? (If yes, circle affected area in the box below):                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| * 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): | <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 <input type="checkbox"/>
Hand/Fingers <input type="checkbox"/>	Chest <input type="checkbox"/>	Upper Back <input type="checkbox"/>	Lower Back <input type="checkbox"/>	Hip <input type="checkbox"/>	Thigh <input type="checkbox"/>
	Knee <input type="checkbox"/>	Calf/Shin <input type="checkbox"/>	Ankle <input type="checkbox"/>	Foot/Toes <input type="checkbox"/>	





## 2018-2019 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(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...

- 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?

Y	N
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

### Family History Questions: Please tell me about any of the following in your family...

- 8) Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accidents, drowning, 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
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- |                                                              | Y                        | N                        |
|--------------------------------------------------------------|--------------------------|--------------------------|
| Enlarged Heart                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertrophic Cardiomyopathy (HCM)                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Dilated Cardiomyopathy (DCM)                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Rhythm problems:                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Long QT Syndrome (LQTS)                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Short QT Syndrome                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Brugada Syndrome                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) | <input type="checkbox"/> | <input type="checkbox"/> |
| Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)       | <input type="checkbox"/> | <input type="checkbox"/> |

- Marfan Syndrome (Aortic Rupture)
- Heart Attack, age 50 or younger
- Pacemaker or Implanted Defibrillator
- Deaf at Birth (Congenital Deafness)

#### 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:



**2018-2019 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*
<b>Medical</b>			
Appearance			
Eyes/Ears/ Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary †			
Skin			
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/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  
 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:

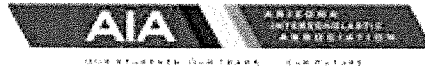
Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or legal guardian must print and sign name below and indicate date signed.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## 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

"I, \_\_\_\_\_, the undersigned, am the parent/legal guardian of, \_\_\_\_\_, a minor and student/athlete at \_\_\_\_\_ 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 \_\_\_\_\_

**Horizon Honors High School  
Horizon Honors Middle School  
Horizon Honors Intermediate School  
Athletic Policy/Procedure & Fee Contract**

Dear Parents and Guardians,

Your student has tried out for and been selected as a member of a team at Horizon. In order to participate it is required that you and your student acknowledge that you have read, understand and accept the requirements documented in the **Athletic Handbook**. The points listed below are intended to highlight some of the details found in the handbook. **By signing this form you are accepting accountability for the entirety of the handbook.**

**Initial Eligibility Requirements:**

- Current behavior must be acceptable to all teachers and administration.
- A current 2.0, or better, grade point average, no failing status in any current class, or previous quarter.
- Acceptance of the responsibility for use of athletic equipment and uniforms. Any misuse or loss will be the financial responsibility of the student and parent.

**Qualification Procedures:**

- Obtain an annual examination by a licensed physician who completes and signs the **AIA Annual Pre-participation Physical Evaluation** by the due date.
- Complete the **AIA Annual Pre-participation Physical Evaluation** form, which provides parental/guardian permission to participate and health history by the due date.
- Complete the **AIA Mild Traumatic Brain Injury (MTBI)/Concussion** form by the due date.
- Complete the **Horizon Athletic Insurance Information and Waiver** form by the due date.
- Sign the **Athletic Policy/Procedure & Fee Contract** by the due date.
- Complete **AIA Brainbook Course Grades 9-12 (must be completed once during 4 years of HS)**
- Submit payment of the Athletic Fee by the due date.
- Turn all forms into the Athletic Assistant by the due date.

**Maintaining Eligibility:**

- Student Athletes are required to maintain a 2.0 Grade Point Average at all times and never have a failing status at any time in any class. Current quarter grades are used to determine eligibility, not semester grades.
- Student Athletes must attend all practices and contests unless there is a pre-approved arrangement with the coach. There is an allowance of two excused absences. More than two excused absences can result in removal from the team. Un-excused absences are never acceptable. Only the Athletic Director can approve an absence due to extenuating circumstances.
- Respectful behavior toward team members, coaches, officials, competitors and fans is required at all athletic events.

I have read and understand the Horizon Athletic Handbook.

_____ Parent/Guardian Signature	_____ Date	_____ Student Signature	_____ Date
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Please check one of the following:

- I/We give permission for the email(s) below to be shared with the Coach, Team Parent, and Athletic Assistant for team updates and news.
- Only use my/our email(s) for direct contact from the Athletic Assistant for team updates and news.
- Father's email \_\_\_\_\_
- Mother's email \_\_\_\_\_

# Horizon Community Learning Center

## Athletic Insurance Information and Waiver

### Medical Authorization:

Student's Name \_\_\_\_\_

Consent is hereby given for the above named individual to participate in athletic activities, conditioning, and weight training at Horizon Community Learning Center. In the event of illness and/or injury, permission is hereby granted for the treatment of this individual whenever medical attention is needed. I am aware that any financial obligations resulting from accident and/or illness, including emergency medical treatment, is solely my responsibility and not that of Horizon Community Learning Center or any of its representatives.

\_\_\_\_\_  
Signature of Parent or Guardian                      Date

\_\_\_\_\_  
Signature of Student                                              Date

### Insurance Information and Waiver:

Student's Name: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number \_\_\_\_\_

Insurance Phone Number \_\_\_\_\_ Billing Address \_\_\_\_\_

### WAIVER, RELEASE, AND INDEMNITY AGREEMENT

I understand that there are risks and dangers inherent in participating in athletic activities, conditioning, and weight training. I have been informed and understand that Horizon Community Learning Center does not provide insurance coverage for athletic, conditioning, or weight training injuries. I also understand that in order for my children to be allowed to participate and/or receive instruction in athletic activities, conditioning, and weight training I must give up my rights to hold Horizon Community Learning Center or any of its representatives liable for any injury or damage which my children may suffer while participating and/or receiving instruction in athletic activities, conditioning, or weight training. I understand and agree that this agreement will be binding on me, my spouse, my heirs, my personal representatives, my assigns, my children and any guardian for my children. I understand and agree that if I am signing this agreement on behalf of my child, that I will be giving up the same right for my child, as I would be giving up if I signed this document on my own behalf. I understand that I am required to have insurance that covers athletic activities, conditioning, and weight training injuries and that without my own insurance coverage my children would not be allowed to participate in any athletic activities, conditioning, or weight training with Horizon Community Learning Center.

I acknowledge that I have read this agreement and that I understand the words and language in it.

\_\_\_\_\_  
Printed Name of Student

\_\_\_\_\_  
Signature of Student                                              Date

\_\_\_\_\_  
Printed Name of Parent/Legal Guardian

\_\_\_\_\_  
Signature of Parent/Legal Guardian                                              Date





# Horizon Honors Middle School/High School Athletic Transportation Release Form

Name of Student: \_\_\_\_\_ Sport: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

The student listed above, who participates in the Horizon Honors Athletic Program, will adhere to the departmental policy for student travel to and from athletic events, including but not limited to practices, games, tournaments, competition, meets and matches. I am fully aware the school and its athletic program offer transportation to competitions and back to the original site of departure. It is my understanding my child will ride to and from the competition in a vehicle provided by Horizon Honors or with me as parent(s)/guardian(s). I understand if my child rides home with someone other than by a Horizon Honors vehicle, it will be the responsibility of the driver to sign the student out with the responsible coach. In my absence, the student has my permission to be transported in the following manner: **(check all that apply)**

When necessary, my child may ride to the game and return home with someone other than a Horizon Honors vehicle or parent/guardian. **Sign out with the coach is required.**

I give permission to the following to transport my child in my absence: (Please print)

1. \_\_\_\_\_  
Name Cell phone number

2. \_\_\_\_\_  
Name Cell phone number

My student will drive to practices and away competitions **(Sign out with the coach is required).**

\*My student understands that my child is not allowed to transport any other students, players, or spectators. Any violation may result in disciplinary action by Athletic Director/Administrator of Horizon Honors HS.

My signature will release Horizon Honors, its coaches and Administrators from all liability for my child. I do this of my own free will and under absolutely no stress. I offer my signature on the coach's sign out sheet as approval to release my Horizon Honors student back into my control and my responsibility. In my absence, I have granted permission to the responsible parties listed above or to my student when given the permission to drive.

Any violations of this policy will result in disciplinary action taken by the team coach, the Horizon Honors Athletic Director and/or the administration of Horizon Honors Middle School/High School as deemed appropriate.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date