



Canyon Athletic Association  
 2033 W. North Lane Suite #19 Phoenix, AZ 85021  
 Phone: 602-687-1645 info@azcaa.com



The Preferred Urgent Care of the  
 Canyon Athletic Association

## 2020-21 SCHOOL YEAR, ANNUAL PRE-PARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete) Exam Date: \_\_\_\_\_

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone/s: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Personal Physician: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

| EMERGENCY CONTACTS |               |               |
|--------------------|---------------|---------------|
| 1) Name            |               | Relationship  |
| Phone (Home):      | Phone (Work): | Phone (Cell): |
| 2) Name            |               | Relationship  |
| Phone (Home):      | Phone (Work): | Phone (Cell): |

| Explain "Yes" answers on the following page. 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 conditional (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 stringing insects? (Please specify):  |     |    |
| 5) Does your heart race or skip beats during exercise?   |     |    |
| 6) Has a doctor ever told you that you have (check all that apply):<br><input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection |     |    |
| 7) Have you ever spent the night in a hospital?  |     |    |
| 8) Have you ever had surgery?  |     |    |



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| Explain "Yes" answers on the following page. Circle questions you don't know the answers to.  | YES | NO |
|---|-----|----|
| 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11)   |     |    |
| 10) Have you had any broken/fractured bones or dislocated joints?<br>(If yes, check affected area in the box below in question 11):   |     |    |
| 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?<br>(If yes, check affected area in the box below):<br><br><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<br><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<br><input type="checkbox"/> Knee <input type="checkbox"/> Calf/Shin <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/Toes |     |    |
| 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 nonfunctioning 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?  |     |    |



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| Explain "Yes" answers on the following page. Circle questions you don't know the answers to.               | YES | NO |
|--|-----|----|
| 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?                                 |     |    |
| <b>FEMALES ONLY</b>  | YES | NO |
| 37) Have you ever had a menstrual period?  |     |    |
| 38) How old were you when you had your first menstrual period?   |     |    |
| 39) How many periods have you had in the last year?  |     |    |
| <b>EXPLAIN "YES" ANSWERS HERE</b>  |     |    |
|  |     |    |



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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...   | YES  | NO |
|---|--|----|
| 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?   |  |    |
| Family History Questions: Please Tell Me About Any Of The Following In Your Family...   | YES  | NO |
| 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:   |  |    |
| <input type="checkbox"/> Enlarged Heart<br><input type="checkbox"/> Hypertrophic Cardiomyopathy (HCM)<br><input type="checkbox"/> Dilated Cardiomyopathy (DCM)<br><input type="checkbox"/> Heart Rhythm Problems<br><input type="checkbox"/> Long QT Syndrome (LQTS)<br><input type="checkbox"/> Short QT Syndrome<br><input type="checkbox"/> Brugada Syndrome<br><input type="checkbox"/> Catecholaminergic Polymorphic Ventricular | <input type="checkbox"/> Tachycardia (CPVT)<br><input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)<br><input type="checkbox"/> Marfan Syndrome (Aortic Rupture)<br><input type="checkbox"/> Heart Attack, Age 50 or Younger<br><input type="checkbox"/> Pacemaker or Implanted Defibrillator<br><input type="checkbox"/> Deaf at Birth |    |
| 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 |



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## 2020-21 SCHOOL YEAR, ANNUAL PRE-PARTICIPATION PHYSICAL EXAMINATION

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

% Body Fat (optional): \_\_\_\_\_

Pulse: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_(\_\_\_\_\_/\_\_\_\_\_.\_\_\_\_\_/\_\_\_\_\_)

Vision: R20/\_\_\_\_ L20/\_\_\_\_ Pupils:  Equal  Unequal Corrected:  Yes  No

|                        | 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/Hands/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  Cleared With Following 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



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## 2020-21 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 Canyon Athletic Association (CAA), \_\_\_\_\_ (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/CAA, 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, 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 OR TYPE**

"I, \_\_\_\_\_, the undersigned, am the parent/legal guardian of, \_\_\_\_\_, a minor and student-athlete at \_\_\_\_\_ (name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/CAA 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/CAA.

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



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**South Arizona Avenue**

3705 S. Arizona Ave., Ste. 1  
 Chandler, AZ 85248  
**480.214.7828**

**West Ray Road**

2875 W. Ray Rd., Ste. 8  
 Chandler, AZ 85224  
**480.899.3070**

**Florence**

495 N. Pinal Pkwy., Ste. 106  
 Florence, AZ 85132  
**520.868.0573**

**Happy Valley Road**

3730 W. Happy Valley Rd.  
 Ste. 100  
 Glendale, AZ 85310  
**623.277.4140**

**Goodyear**

1507 N. Litchfield Rd. Ste. 200  
 Goodyear, AZ 85395  
**623.215.0040**

**North Silverbell Road**

7850 N. Silverbell Rd. Ste. 132  
 Marana, AZ 85743  
**520.407.5884**

**South Power Road**

1810 S. Power Rd., Ste. 101  
 Mesa, AZ 85206  
**480.214.0045**

**Baseline & Signal Butte Road**

1955 S. Signal Butte Rd.  
 Ste. 103  
 Mesa, AZ 85209  
**480.214.4466**

**West University Drive**

835 W. University Dr.  
 Mesa, AZ 85201  
**480.664.6007**

**Val Vista Drive**

415 N. Val Vista Dr., Ste. 101  
 Mesa, AZ 85213  
**480.654.5661**

**19th Avenue**

5201 N. 19th Ave., Ste. 100  
 Phoenix, AZ 85015  
**602.795.1411**

**44th Street**

2301 N. 44th St.  
 Phoenix, AZ 85008  
**602.808.8786**

**Bell Road**

401 E. Bell Rd., Ste. 18  
 Phoenix, AZ 85022  
**602.368.1403**

**Indian School Road**

8260 W. Indian School Rd.,  
 Ste. 1  
 Phoenix, AZ 85033  
**623.846.7122**

**Maryvale Parkway**

5259 W. Indian School Rd.,  
 Ste. 100  
 Phoenix, AZ 85031  
**623.888.5101**

**Peoria Avenue**

2860 W. Peoria Ave.  
 Ste. B  
 Phoenix, AZ 85029  
**602.283.0595**

**Thunderbird Road**

3131 E. Thunderbird Rd. Ste. A  
 Phoenix, AZ 85032  
**602.283.3609**

**McDowell Road**

7730 E. McDowell Rd. Ste. 101  
 Scottsdale, AZ 85257  
**480.699.3314**

**East Shea Boulevard**

4902 E. Shea Blvd.  
 Ste. 101  
 Scottsdale, AZ 85254  
**480.214.4468**

**Surprise**

12775 W. Bell Rd., Ste. 100  
 Surprise, AZ 85378  
**623.215.0082**

**Baseline Road**

2720 W. Baseline Rd. Ste. 140  
 Tempe, AZ 85283  
**602.777.6000**

**Elliot Road**

1804 W. Elliot Rd.  
 Tempe, AZ 85284  
**480.456.0444**

**Mill Avenue**

3244 S. Mill Ave., Ste. 101  
 Tempe, AZ 85282  
**480.214.0621**

**University ASU**

725 South Rural Road,  
 Ste. 120  
 Tempe, AZ 85281  
**480.214.0622**

**Lower Buckeye Road**

9870 W. Lower Buckeye Rd.,  
 Ste. 170  
 Tolleson, AZ 85353  
**623.215.0189**

**22nd Street**

5594 E. 22nd St.  
 Tucson, AZ 85711  
**520.232.2047**

**Broadway Boulevard**

2510 E. Broadway Blvd.  
 Tucson, AZ 85716  
**520.232.2072**

**North Swan Road**

2460 N. Swan Rd.  
 Ste. 140  
 Tucson, AZ 85712  
**520.441.5405**

**West Valencia Road**

1895 W. Valencia Rd.  
 Ste. 101  
 Tucson, AZ 85746  
**520.576.5104**

\*Sports medicine at select clinics. Visit [FastMed.com](http://FastMed.com) for details. Holiday hours vary by clinic; call clinic or check online for details.