

# Football ONLY

## *Fountain Hills Middle School*

### *Athletic Waiver Form*

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Registration Information (Please print)

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

Parent Name or Legal Guardian Name \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Day or Cell Phone Number \_\_\_\_\_

Parent's E-mail Address \_\_\_\_\_

Emergency Contact and Phone Number \_\_\_\_\_

Insurance/Medical Care

Medical Insurance will not be provided by Fountain Hills Middle School. The parental authorization and insurance information must be completed with the registration form. Insurance information must be complete or the Student will not participate. If applicable, a doctor's release must be attached if the student is recovering from a recent illness or injury, or if he is participating with a cast or splint. Note: Athletics include a great deal of physical activity. Participants are encouraged to be properly conditioned.

Insurance carrier: \_\_\_\_\_ Policy Number \_\_\_\_\_

Limitation and Waiver of Liability

In partial consideration of our child's participation in Fountain Hills Middle School athletics, I/we as a parent/s of Student's Name \_\_\_\_\_

do hereby waive all liability of Fountain Hills Middle School, its employees, agents, board members, and staff for any accident, injury (including death), illness, or other mishap which might befall the above-named student while traveling to/from or during his attendance at Fountain Hills Middle School athletic events. Further, I/we hereby grant permission to the staff of Fountain Hills Middle School and any hospital staff to render to the above-named student, any emergency medical services deemed necessary. I/we understand that all possible efforts will be made to inform me/us in case of such treatment.

Parent or Legal Guardian's Name (print) \_\_\_\_\_

Parent or Legal Guardian's Name (signature) \_\_\_\_\_

Date \_\_\_\_\_



Arizona Interscholastic Association, Inc.

# 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: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W) \_\_\_\_\_

Cell Phone: \_\_\_\_\_

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

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

	Yes	No
9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="radio"/>	<input type="radio"/>
Do you have asthma?	<input type="radio"/>	<input type="radio"/>
Do you use an inhaler?	<input type="radio"/>	<input type="radio"/>
Do you have seasonal allergies that require medical treatment?	<input type="radio"/>	<input type="radio"/>
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)?	<input type="radio"/>	<input type="radio"/>
11. Have you had any problems with your eyes or vision?	<input type="radio"/>	<input type="radio"/>
Do you wear glasses, contacts, or protective eyewear?	<input type="radio"/>	<input type="radio"/>
12. Have you ever had a sprain, strain, or swelling after injury?	<input type="radio"/>	<input type="radio"/>
Have you broken or fractured any bones or dislocated any joints?	<input type="radio"/>	<input type="radio"/>
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="radio"/>	<input type="radio"/>
<i>If yes, check appropriate box below:</i>		
<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/calf
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
<input type="checkbox"/> Upper arm		<input type="checkbox"/> Foot
13. Do you want to weigh more or less than you do now?	<input type="radio"/>	<input type="radio"/>
Do you lose weight regularly to meet weight requirements for your sport?	<input type="radio"/>	<input type="radio"/>
14. Do you feel stressed?	<input type="radio"/>	<input type="radio"/>
15. Do you or have you ever used:	<input type="radio"/>	<input type="radio"/>
Smokeless tobacco _____ Cigarettes _____		
Alcohol _____ Recreational drugs _____		
<b>Females Only</b>		
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 Student Athlete \_\_\_\_\_ Date \_\_\_\_\_



**2016-2017 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION**

The Parent or Guardian should fill out this form with assistance from the student athlete.)

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

Name: \_\_\_\_\_  
 Sex: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Grade: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Sport(s): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Personal Physician: \_\_\_\_\_  
 Hospital Preference: \_\_\_\_\_

**In case of emergency, contact:**

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

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 <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection <input type="checkbox"/> | <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?<br>(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, circle affected area in the box below):  | <input type="checkbox"/> | <input type="checkbox"/> |

Head  Neck  Shoulder  Upper Arm  Elbow  Forearm

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

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

**Females Only**

	Y	N
38) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
39) How old were you when you had your first menstrual period?		
40) How many periods have you had in the last year?		

**Explain "Yes" Answers Here**

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

**NextCare**  
 URGENT CARE

The Preferred Health Care  
 Partner of the Arizona  
 Interscholastic Association

**2016-2017 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...

	Y	N
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>

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

	Y	N
1) Are there any family members who had sudden, unexpected, unexplained death before age 50? (Including SIDS, car accidents, drowning, or car drowning)	<input type="checkbox"/>	<input type="checkbox"/>
2) Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
3) Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
4) Are there any relatives with certain conditions, such as:	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack, age 50 or younger	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Deaf at Birth (Congenital Deafness)	<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given accurate and accurate information in response to the above questions.

Signature of athlete \_\_\_\_\_

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

**2016-2017 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 % Body fat (optional): \_\_\_\_\_ Pulses: \_\_\_\_\_  
 BP: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Corrected: Y  N   
 Vision: R20/ \_\_\_\_\_ L20/ \_\_\_\_\_  
 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: \_\_\_\_\_  
 Phone: \_\_\_\_\_

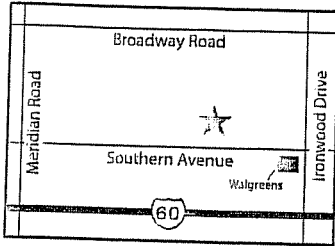
# NextCare<sup>®</sup>

## URGENT CARE

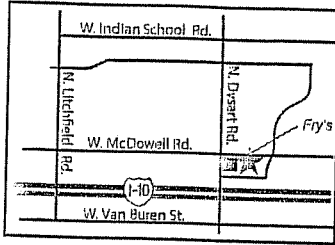
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Arizona Interscholastic Association

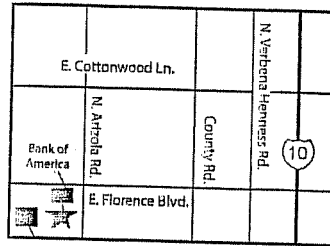
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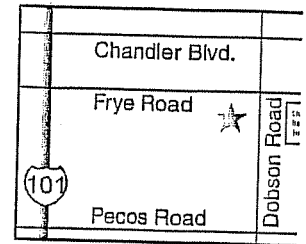
**Apache Junction • 85120**  
2080 West Southern Ave., Suite #A1



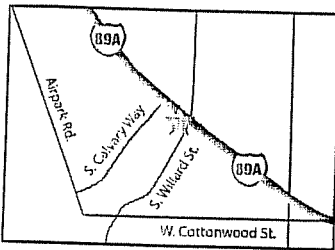
**Avondale • 85392**  
13075 W. McDowell Rd., Suite #D106



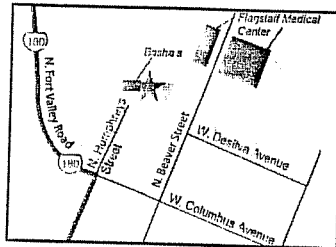
**Casa Grande • 85122**  
1683 E. Florence Blvd., Suite #7



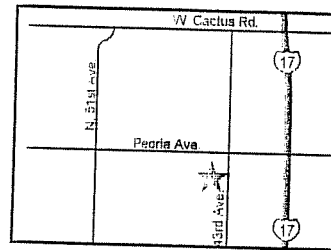
**Chandler • 85224**  
600 S. Dobson Road, Suite #C-



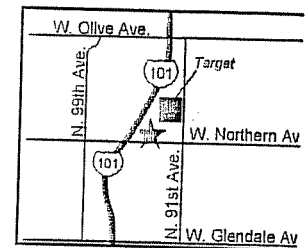
**Cottonwood • 86326**  
450 S. Willard Street, Suite #120



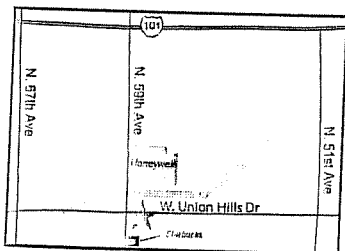
**Flagstaff • 86001**  
1000 N. Humphreys St., Suite #104



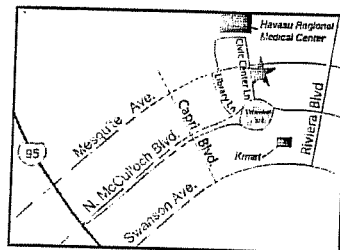
**Glendale • 85302**  
10240 N. 43rd Ave., Suite #3



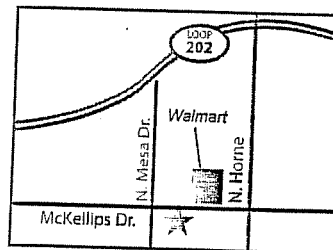
**Glendale • 85305**  
9494 W. Northern Ave., Suite #1



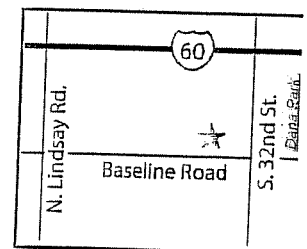
**Glendale • 85308**  
18589 N. 59th Ave., Suite #101



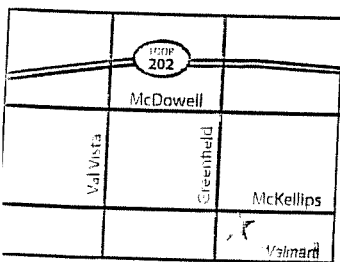
**Lake Havasu City • 86403**  
1810 Mesquite Ave., Suite B



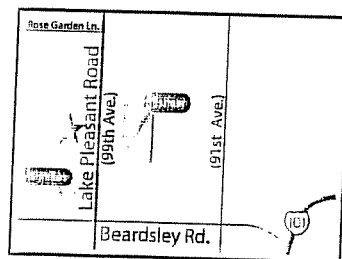
**Mesa • 85203**  
535 E. McKellips Road, Suite #101



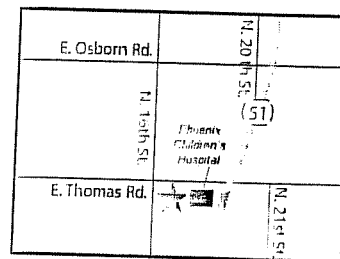
**Mesa • 85204**  
3130 E. Baseline Road, Suite #



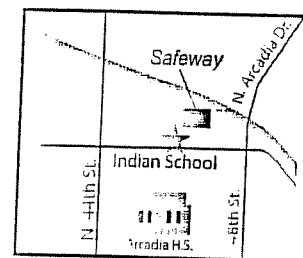
**Mesa • 85215**  
401 E. McKellips Road, Suite #102



**Peoria • 85382**  
20470 N. Lake Pleasant Rd., Suite #102



**Phoenix • 85016**  
1701 E. Thomas Road, Suite #A104



**Phoenix • 85018**  
4730 E. Indian School Rd., Suite

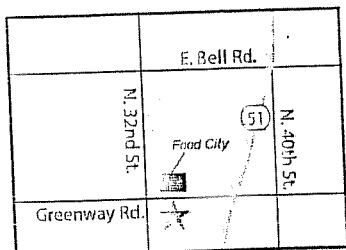
# NextCare

## URGENT CARE

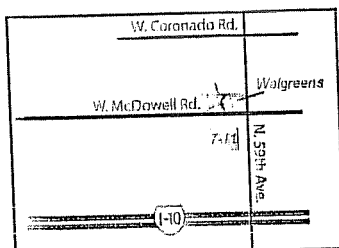
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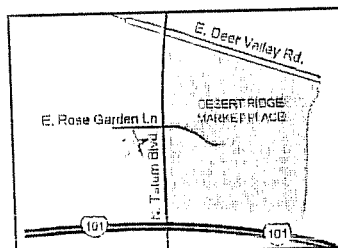
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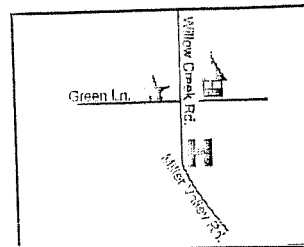
**Phoenix • 85032**  
3229 E. Greenway Rd., Suite #102



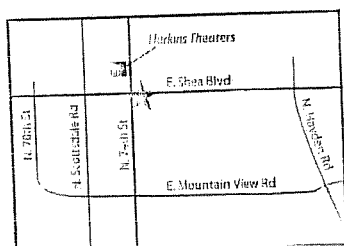
**Phoenix • 85035**  
5920 W. McDowell Road



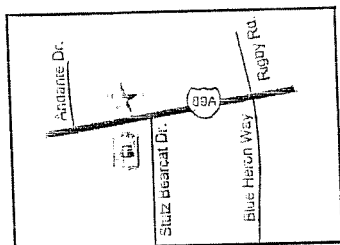
**Phoenix • 85050**  
20950 N. Tatum Blvd., Suite #190



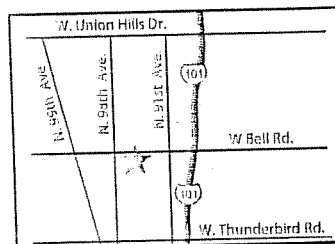
**Prescott • 86301**  
2062 Willow Creek Road



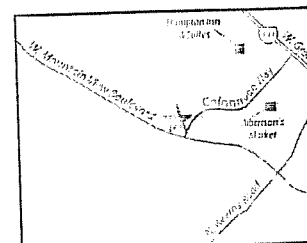
**Scottsdale • 85260**  
7425 E. Shea Blvd., Suite #108



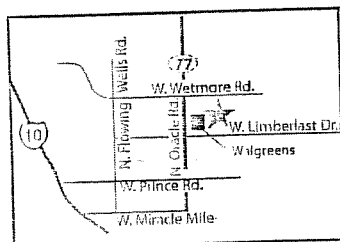
**Sedona • 86336**  
2530 W. SR 89A, Suite #A



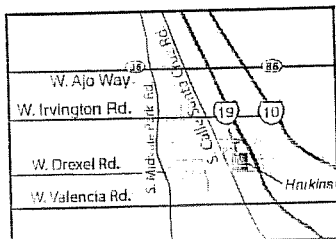
**Sun City • 85351**  
9745 W. Bell Road, Suite #105



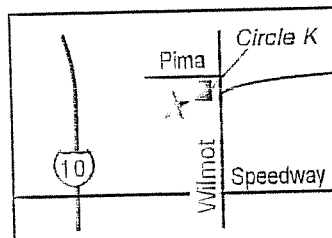
**Surprise • 85374**  
14800 W. Mtn. View Blvd., Suite



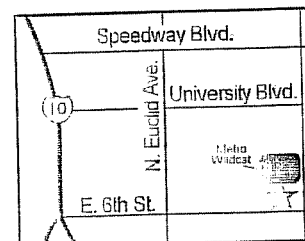
**Tucson • 85705**  
4280 North Oracle Rd., Suite #100



**Tucson • 85706**  
5369 S. Calle Santa Cruz, Suite #145



**Tucson • 85712**  
6238 E. Pima Street



**Tucson • 85719**  
501 North Park Ave., Suite #110