



AJO UNIFIED SCHOOL DISTRICT #15

111 N. WELL RD

AJO, AZ 85321

PARENT PERMISSION FOR ATHLETIC PARTICIPATION

STUDENT: _____ GRADE: _____

I/We give our permission for my/our son/daughter to participate in organized athletics. I/We understand that such activities involve the potential for injury which is inherent in all sports. I/We acknowledge that even with the best coaching, use of most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions, these injuries can be severe as to result in a total disability, paralysis, or death.

It is strongly recommended that students, who participate in the sport programs sponsored by Ajo Junior and Senior High Schools, have medical insurance. I/We understand and agree that Ajo Unified School District #15 is not financially liable for accidents or injuries resulting from the participation of my/our son/daughter in a school sponsored event. I/We will assume responsibility for medical or accident insurance during school sponsored activity in which my/our son/daughter participates during the school year.

I/We have read the above information and hereby give my/our consent for:

to participate in the Interscholastic Athletic Program at Ajo Junior/Senior High School.

Parent Signature: _____ Date: _____



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

HONORHEALTH™



The Preferred Urgent Care of the Canyon Athletic Association

2023-24 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): <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.

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?

FEMALES ONLY

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?

EXPLAIN "YES" ANSWERS HERE

COVID

1) Has your child been diagnosed with COVID-19?

1a) If yes, is your child having any symptoms from their COVID-19 infection?

2) Was your child hospitalized as a result from complications of COVID-19?

3) Has your child been diagnosed with Multi-inflammatory Syndrome in Children (MIS-C)?

4) Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist)?

5) Has your child returned back to full participation in sports?

6) Has your child direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?

7) Did your child receive the COVID-19 vaccine?

7a) What was the manufacturer of the vaccine?

7b) Date of vaccination(s)



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2023-24 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*
Medical			
Appearance			
Eyes/Ears/Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary &			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hands/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

*Multi-examiner set-up only / ⁶Having 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