# ATHLETIC INFORMATION



**PV**Schools<sup>®</sup> Athletics

OTE: Physical exam date must b <u>after</u> March 1, 2019.

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Bitchen Name:         DP:         Birthdate:         /         Gender:         Grade:           Home Address:         City:         Zip:         Zip:           Parent Name:         Home Phone :         Cell Phone:         Cell Phone:           School(s) attended last year:         Relationship:         Phone:         Cell Phone:           School(s) attended last year:         If PARENT OR GURADIAN CANNOT BE REACHED IN AN EMERGENCY, PLEAE CONTACT:         Name:           Name:         Home Phone:         Cell Phone:         Cell Phone:           Intervely give consent for coaches, trainers or a team physician to use their judgement in securing medical ail in emergencies.         INSURANCE; Student Athlete MUST have medical insurance coverage. THE PARADISE VALLEY UNIFIED SCHOOL DISTRICT DOES NOT FROVIDE HEALTH INSURANCE FOR STUDENT ATHLETES. Parents must obtain insurance, as they are responsible for medical bis incurreds at result of phanicpation in athletics. Parents must obtain insurance, as they are responsible for medical bis incurreds decided insurance.         YES         NO           Inave purchased school misurance:         YES         NO         Inave purchased school misures.         YES         NO           Inave purchased school misures:         YES         NO         Inave purchased atheeit participation in thin team provide in trainer provide in trainere proveminstrance and provemes trainere provemes trainer provem															•	
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Insurance Company:         Policy#:           BRAINBOCK:         ALL athletes are required by the AIA to complete a concussion education course as well as pass a test at the end of the course with a minimum score of 80% before they are allowed to complete in any sport. A certificate of completion must be printed and turned in. The website for this course is <a href="http://diaacademy.org">http://diaacademy.org</a> . This course oily needs to be completed one time prior to participating in their first District organized athletic sport.           STUDENT ATHLETE DRUG TESTING CONSENT:         WE HAVE READ AND UNDERSTAND The Paradise Valley Unified School District Parent and Athlete Informed Consent and Random Drug Testing Handbook. I will allow my son/daughter to participate in this drug program. while participating as a high-school of obtaining urine samples, testing and analysis of such specimens and all other aspects of the program. Laccept the method of obtaining urine samples, testing and analysis of such specimens and all other aspects of the program. Jaccept the program. This consent is given pursuent to all state and federal privacy statutes and constitutional and common law privacy provisions and is a waiver of right to nondisclosure of such test records and results, only to the extent of the disclosure authorized in the program.           PERMISSION TO TRANSPORT:         IWWE give the District permission for our son/daughter to be transported by District vehicles to away games and off-site practices as required.           EQUIPMENT CODE:         It is the athlete's responsibility to care for and return all equipment issued to our son/daughter is the property of the high school and must be returned in reasonable condition. Items lost, stolen, or abused must be relaced and the Athletic Department reimbursed for the cosid the equipment. <td>NOT PR bills incu</td> <td>ROVI arrec</td> <td>DE HEAL as a resu</td> <td>TH I ult of</td> <th>NSURAN</th> <td>CE tion</td> <th>FOR ST in athleti</th> <td>UDE ics. F</td> <td>NT ATH Parents</td> <td>ILETES must p</td> <td>5. Pa rovic</td> <td>arents must obtair de insurance infor</td> <td>n insurance mation to a</td> <td>, as the</td> <td>ey are responsible</td> <td>e for medical</td>	NOT PR bills incu	ROVI arrec	DE HEAL as a resu	TH I ult of	NSURAN	CE tion	FOR ST in athleti	UDE ics. F	NT ATH Parents	ILETES must p	5. Pa rovic	arents must obtair de insurance infor	n insurance mation to a	, as the	ey are responsible	e for medical
BRAINBOOK:       ALL athletes are required by the AIA to complete a concussion education course as well as pass a test at the end of the course with a minimum score of 80% before they are allowed to compete in any sport. A certificate of completion must be printed and turned in. The website for this course is http://aiaacademy.org.         STUDENT ATHLETE DRUG TESTING CONSENT:       IWE HAVE READ AND UNDERSTAND The Paradise Valley Unified School District and hereby voluntarily agree to be subject to the terms of the prevention program. I accept the method of obtaining urine samples, testing and analysis of such specimens and all other aspects of the program. I agree to cooperate to in furnishing urine samples, testing and analysis of such specimens and all other aspects of the program. I agree to cooperate in furnishing urine samples, testing and analysis of such specimens and all other aspects of the program. I agree to cooperate in furnishing urine specimens that may be required from time to time. I further agree and consent to the disclosure of the sampling, testing, and results as provided in the program. To consent is given pursuant to all state and federal privacy strutes and constitutional and common law privacy provisions and is a waiver of right to nondisclosure of such test records and results, only to the extent of the disclosure authorized in the program. The agree that all equipment issued by the high school. I/WE give the District permission for our son/daughter to be transported by District vehicles to away games and off-site prediced and analysis (be care for and return all equipment issued by the high school. I/WE understand and agree that all equipment issued to our son/daughter is the property of the high school and must be returned in reasonable condition. Items toat, southen, or abused must be related and the Athletic Department reimbursed for the cost of the equipment.         EQUIPMENT COD	I have pu	Ircha	<mark>sed schoo</mark>	l ins	urance:		YES		NO		۱h	nave my own insura	ance:		YES	NO
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RELEASE OF NAME AND /OR IMAGE: I/WE give the District permission for my/our son/daughter to be photographed while participating in District sporting events, and for such photographs to be used in various media publications and formats, including but not limited to web pages, newspaper articles, district publications, and/or district site newsletters. I/WE also agree to allow such photographs to be captioned from time to time with my/our son's/daughters complete name.         PARENT/GUARDIAN SIGNATURE:       DATE:         PARENT CONSENT SPORTS INJURY VIDEO: In order to participate in District organized athletics, each student together with their parent or guardian must view the online Parent Consent Sports Injury Video prior to participating in their first District organized athletic sport. A link to this video can be found at <a href="http://youtu.be/rtTJR9KNVWQ">http://youtu.be/rtTJR9KNVWQ</a> BY SIGNING BELOW, I CONFIRM THAT MY STUDENT ATHLETE AND I HAVE VIEWED THE ONLINE VIDEO AND UNDERSTAND THE RISKS INVOLVED PARTICIPATING IN DISTRICT ATHLETICS.         PARENT/GUARDIAN SIGNATURE:       DATE:         I/WE have read, understand and will abide by the statements listed on all pages of this packet.       DATE:	minimum is http://ai STUDEN Athlete In school ath method o specimen program. to nondisc PERMIS practices EQUIPM equipmen replaced a Statement	minimum score of 80% before they are allowed to compete in any sport. A certificate of completion must be printed and turned in. The website for this course is <a href="http://aiaacademy.org">http://aiaacademy.org</a> . This course only needs to be completed one time prior to participating in their first District organized athletic sport. STUDENT ATHLETE DRUG TESTING CONSENT: I/WE HAVE READ AND UNDERSTAND The Paradise Valley Unified School District Parent and Athlete Informed Consent and Random Drug Testing Handbook. I will allow my son/daughter to participate in this drug program while participating as a high-school athlete in the Paradise Valley Unified School District and hereby voluntarily agree to be subject to the terms of the prevention program. I accept the method of obtaining urine samples, testing and analysis of such specimens and all other aspects of the program. I agree to cooperate in furnishing urine specimens that may be required from time to time. I further agree and consent to the disclosure of the sampling, testing, and results as provided in the program. This consent is given pursuant to all state and federal privacy statutes and constitutional and common law privacy provisions and is a waiver of right to nondisclosure of such test records and results, only to the extent of the disclosure authorized in the program. PERMISSION TO TRANSPORT: I/WE give the District permission for our son/daughter to be transported by District vehicles to away games and off-site practices as required. EQUIPMENT CODE: It is the athlete's responsibility to care for and return all equipment issued by the high school. I/WE understand and agree that all equipment issued to our son/daughter is the property of the high school and must be returned in reasonable condition. Items lost, stolen, or abused must be replaced and the Athletic Department reimbursed for the cost of the equipment. CODE OF CONDUCT/HANDBOOK: I/WE have read and understand the information in the Informed Consent Handbook,														
District sporting events, and for such photographs to be used in various media publications and formats, including but not limited to web pages, newspaper articles, district publications, and/or district site newsletters. I/WE also agree to allow such photographs to be captioned from time to time with my/our son's/daughters complete name.         PARENT/GUARDIAN SIGNATURE:       DATE:         PARENT CONSENT SPORTS INJURY VIDEO:       In order to participate in District organized athletics, each student together with their parent or guardian must view the online Parent Consent Sports Injury Video prior to participating in their first District organized athletic sport. A link to this video can be found at <a href="http://youtu.be/rtTJR9KNVWQ">http://youtu.be/rtTJR9KNVWQ</a> BY SIGNING BELOW, I CONFIRM THAT MY STUDENT ATHLETE AND I HAVE VIEWED THE ONLINE VIDEO AND UNDERSTAND THE RISKS INVOLVED PARTICIPATING IN DISTRICT ATHLETICS.         PARENT/GUARDIAN SIGNATURE:       DATE:         I/WE have read, understand and will abide by the statements listed on all pages of this packet.         PARENT/GUARDIAN SIGNATURE:       DATE:																
PARENT CONSENT SPORTS INJURY VIDEO:       In order to participate in District organized athletics, each student together with their parent or guardian <u>must view</u> the online Parent Consent Sports Injury Video prior to participating in their first District organized athletic sport. A link to this video can be found at <a href="http://youtu.be/rtTJR9KNVWQ">http://youtu.be/rtTJR9KNVWQ</a> BY SIGNING BELOW, I CONFIRM THAT MY STUDENT ATHLETE AND I HAVE VIEWED THE ONLINE VIDEO AND UNDERSTAND THE RISKS INVOLVED PARTICIPATING IN DISTRICT ATHLETICS.         PARENT/GUARDIAN SIGNATURE:       DATE:         I/WE have read, understand and will abide by the statements listed on all pages of this packet.         PARENT/GUARDIAN SIGNATURE:       DATE:	<b>RELEASE OF NAME AND /OR IMAGE:</b> I/WE give the District permission for my/our son/daughter to be photographed while participating in District sporting events, and for such photographs to be used in various media publications and formats, including but not limited to web pages, newspaper articles, district publications, and/or district site newsletters. I/WE also agree to allow such photographs to be captioned from time to time with my/our son's/daughters complete name.															
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I/WE have read, understand and will abide by the statements listed on all pages of this packet.           PARENT/GUARDIAN SIGNATURE:         DATE:	or guardian <u>must view</u> the online Parent Consent Sports Injury Video prior to participating in their first District organized athletic sport. A link to this video can be found at <u>http://youtu.be/rtTJR9KNVWQ</u> BY SIGNING BELOW, I CONFIRM THAT MY STUDENT ATHLETE AND I HAVE VIEWED THE ONLINE VIDEO AND UNDERSTAND THE RISKS INVOLVED PARTICIPATING IN DISTRICT ATHLETICS.															
PARENT/GUARDIAN SIGNATURE: DATE:	PAREN	r/Gl														
			I/W	'E ha	ave read,	une	derstand	and	will ab	ide by t	the s	statements listed	on all pag	es of t	his packet.	
STUDENT SIGNATURE: DATE:	PAREN	T/Gl	JARDIAN	SIG	NATURE:								D	ATE:		
	STUDEN	NT S	IGNATUR	E:									D	ATE:		





The Preferred Health Care Partner of the Arizona Interscholastic Association

## **2019-20 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION**

(The	parent or guardian should	fill out this form with a	assistance from the stud	lent-athlete) Exar	n Date:		
	me Address:			Name:			
	one:				Relationship:		
	te of Birth:			I IFNONE I HOMEI			
	e: nder:						
	ade:						
	nool:						
	ort(s):						
	sonal Physician:						
Ho	spital Preference:			] ]			
				Phone (Work):			
	olain "Yes" answers on th cle questions you don't k			Phone (Cell): _			
Cirv		now me unswers to.					
1) 2) 3)	Y       N         Has a doctor ever denied or restricted your participation in sports for any reason?       Image: Construction of the sport of the spo						
4)	Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify):						
5)	Does your heart race or skip beats during exercise?						
	Does your heart race or	skip beats during e	xercise?				
6)	Does your heart race or Has a doctor ever told y						
6)		ou that you have (cl	neck all that apply):		oction		
,	Has a doctor ever told y High Blood Pressure	ou that you have (cl A Heart Murmur	neck all that apply): High Choleste		ection		
7)	Has a doctor ever told y High Blood Pressure Have you ever spent the	ou that you have (ch A Heart Murmur e night in a hospital	neck all that apply): High Choleste		ection		
,	Has a doctor ever told y High Blood Pressure	ou that you have (ch A Heart Murmur e night in a hospital gery? njury (sprain, muscle	neck all that apply): High Choleste ? e/ligament tear, tend	erol A Heart Infe initis, etc.) that caused	1		
7) 8) 9)	Has a doctor ever told y High Blood Pressure Have you ever spent the Have you ever had surg Have you ever had an i	You that you have (ch A Heart Murmur e night in a hospital gery? njury (sprain, muscle or game? (If yes, che en/fractured bones o	neck all that apply): High Choleste ? e/ligament tear, tendi ck affected area in th or dislocated joints?	erol A Heart Infe initis, etc.) that caused	1		
7) 8) 9) 10)	Has a doctor ever told y High Blood Pressure Have you ever spent the Have you ever had surg Have you ever had an i you to miss a practice of Have you had any brok	You that you have (ch A Heart Murmur e night in a hospital gery? njury (sprain, muscle or game? (If yes, che en/fractured bones of rea in the box below oint injury that requi	heck all that apply): High Choleste ? e/ligament tear, tendi ck affected area in th or dislocated joints? v in question 11) ired X-rays, MRI, CT, s	erol A Heart Infe initis, etc.) that caused le box below in questions surgery, injections, reh	on 11) abilitation		
7) 8) 9) 10)	Has a doctor ever told y High Blood Pressure Have you ever spent the Have you ever had surg Have you ever had an i you to miss a practice of Have you had any brok (If yes, check affected a Have you had a bone/je	You that you have (ch A Heart Murmur e night in a hospital gery? njury (sprain, muscle or game? (If yes, che en/fractured bones of rea in the box below oint injury that requi	heck all that apply): High Choleste ? e/ligament tear, tendi ck affected area in th or dislocated joints? v in question 11) ired X-rays, MRI, CT, s	erol A Heart Infe initis, etc.) that caused le box below in questions surgery, injections, reh	on 11) abilitation	Forearm	
7) 8) 9) 10)	Has a doctor ever told y High Blood Pressure Have you ever spent the Have you ever had surg Have you ever had an i you to miss a practice of Have you had any brok (If yes, check affected a Have you had a bone/je physical therapy, a brac	You that you have (ch A Heart Murmur e night in a hospital gery? njury (sprain, muscle or game? (If yes, che en/fractured bones of rea in the box below oint injury that requi	heck all that apply): High Choleste ? e/ligament tear, tendi ck affected area in th or dislocated joints? v in question 11) ired X-rays, MRI, CT, s	erol A Heart Infe initis, etc.) that caused te box below in questions surgery, injections, ref red area in the box be	on 11) nabilitation low)	Forearm Thigh	





Y Ν 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? 26) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners? 27) While 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? **Explain** "Yes" Answers Here Females Only Y Ν 38) Have you ever had a menstrual period? 39) How old were you when you had your first menstrual period? 40) How many periods have you had in the last year?





The Preferred Health Care Partner of the Arizona Interscholastic Association

### 2019-20 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name:

Date of Birth:

# Y N 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...

			Y	Ν	
8) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowing or near drowning)					
9)	Are there any family members who died suddenly of "heart problem	ns" before age 50?			
10)	Are there any family members who have unexplained fainting or se	izures?			
11)	Are there any relatives with certain conditions, such as:				
	Y N		Y	Ν	
	Enlarged Heart Cate	cholaminergic Polymorphic Ventricular Tachycardia (CPVT)			
	Hypertrophic Cardiomyopathy (HCM) Arrh	/thmogenic Right Ventricular Cardiomyopathy (ARVC)			
	Dilated Cardiomyopathy (DCM) Mart	an Syndrome (Aortic Rupture)			
	Heart Rhythm Problems Hear	Heart Attack, Age 50 or Younger			
	Long QT Syndrome (LQTS) Pace	maker or Implanted Defibrillator			
	Short QT Syndrome Deaf at Birth				
	Brugada Syndrome				

# 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	
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Signature of Parent/Guardian

Date

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP

Date





### 2019-20 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name:			Date of Birth:		
Age:			Sex:		
Height:			Weight:		
% Body Fa	t (optional):		Pulse:		
			BP: / ( /, /)		
Vision:	R20/	L20/	Corrected: Y N		
Pupils:	Equal	Unequal			

	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

& - Having a third party present is recommended for the genitourinary examination

NOTES:

Cleared Without Restriction						
Cleared With Follo	wing Restriction	·				
Not Cleared For:	All Sports	Certain Sports:	Reason:			
Recommendations	:					
Name of Physician (P	rint/Type):		Exam Date:			
Address:			Phone:			
Signature of Physiciar	n:	, MD/DO/ND/NMD/NP/PA-C/CCSP				

FORM 15.7-B 01/14/2019 (rev.) NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.



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 (<u>http://www.cdc.gov/concussion/HeadsUp/youth.html</u>) 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	n name below and indicate date signed.
Print Name:	Signature:
Date:	
FORM 15.7-C 06/15	





### 2019-20 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 OR TYPE

"I,

the undersigned, am

the parent/legal guardian

\_\_\_\_, 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/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 such services 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: \_\_\_\_\_

of,



Banner<sup>\*</sup> Physical Therapy & Rehabilitation In partnership with Select Medical

in paralelising with concernicate

NORTH CANYON

PINNACLE

HORIZON

SHADOW MOUNTAIN

**PARADISE VALLEY** 

### ATHLETICS CONSENT FOR EMERGENCY CARE/TREATMENT

Student Name:		
Date of Birth: / /	Student ID #:	Grade:
Fall Sport(s):	Winter Sport(s):	Spring Sport(s):

In the event that an athletic injury or illness should occur to the above named student athlete while participating in a sanctioned athletic activity at a Paradise Valley Unified School District site, I give my permission for them to receive proper/necessary care from a certified/licensed athletic trainer, physician or other health care individual representing Banner Physical Therapy Outpatient Division. Furthermore, in the event that a medical emergency should occur and I cannot be contacted, I give my permission for a Banner Physical Therapy health representative to arrange for ambulance service to the nearest medical facility. I also give permission for the staff of the medical facility to render treatment, which is considered necessary for the student-athletes wellbeing and health.

Parent or Guardian Name:						
Mailing Address:						
Father's Phone Numbers:	Primary:	Secondary:				
Mother's Phone Numbers:	Primary:	Secondary:				
IN CASE OF EM	ERGENCY AND PARENT/GUARDIAN CANNOT	BE REACHED, PLEASE CONTACT:				
Friend/Relative Name:		Phone:				
Friend/Relative Name:		Phone:				
Family Physician:		Phone:				
Hospital:	·					
Insurance Company:		Policy Number:				
PLEASE LIST ANY MEDICAL CONDITIONS/MEDICATIONS/ALLERGIES BELOW:						

I have carefully read this agreement and I fully understand its contents and I sign of my own free will.

Parent/Guardian Signature: