

NORTH POINTE ATHLETICS
2019-2020

Athlete Information

First Name: _____ **Middle Initial:** ___ **Last Name:** _____

Gender: Female/Male

Grade: 7th 8th 9th 10th 11th 12th

Sports You Intend to Play: Fall _____
 Winter _____
 Spring _____

Address: _____ **Suite/Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone Number: _____

Cell Phone Number: _____

Previous School Information
(10th - 12th Graders)

Are you a new transfer student to North Pointe this school year:
YES/NO

What school did you attend prior to North Pointe Prep: _____

What years did you attend the prior school: _____

What grades did you attend at the previous school: _____



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: _____



2019-20 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: _____
 Gender: _____
 Grade: _____
 School: _____
 Sport(s): _____
 Personal Physician: _____
 Hospital Preference: _____

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

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

Explain "Yes" answers on the 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 conditional (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? (Please specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Do you have allergies to medicines, pollens, foods or stringing insects?
(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):
<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? | <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, check affected area in the box below in question 11) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Have you had any broken/fractured bones or dislocated joints?
(If yes, check affected area in the box below in question 11): | <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"/> |
| <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 | | |

- | | Y | N |
|---|--------------------------|--------------------------|
| 12) Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14) Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15) Has a doctor told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16) Do you cough, wheeze or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17) Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18) Have you ever used an inhaler or taken asthma medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20) Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21) Do you have any rashes, pressure sores or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22) Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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")? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24) Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26) While exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28) Have you ever been tested for sickle cell trait? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29) Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30) Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31) Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32) Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33) Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34) Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35) Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36) Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |

Females Only

Explain "Yes" Answers Here

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



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: _____

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		Y	N
8) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents, drowning or near drowning)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
9) Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
10) Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
11) Are there any relatives with certain conditions, such as:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>	Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, Age 50 or Younger	<input type="checkbox"/>	<input type="checkbox"/>
Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Deaf at Birth	<input type="checkbox"/>	<input type="checkbox"/>
Brugada Syndrome	<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 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 _____



2019-20 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 *
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 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