



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

2021-22 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.	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? (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? (If yes, check affected area in the box below): <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		
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?		
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		



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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 <input type="checkbox"/> Hypertrophic Cardiomyopathy (HCM) <input type="checkbox"/> Dilated Cardiomyopathy (DCM) <input type="checkbox"/> Heart Rhythm Problems <input type="checkbox"/> Long QT Syndrome (LQTS) <input type="checkbox"/> Short QT Syndrome <input type="checkbox"/> Brugada Syndrome <input type="checkbox"/> Catecholaminergic Polymorphic Ventricular	<input type="checkbox"/> Tachycardia (CPVT) <input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) <input type="checkbox"/> Marfan Syndrome (Aortic Rupture) <input type="checkbox"/> Heart Attack, Age 50 or Younger <input type="checkbox"/> Pacemaker or Implanted Defibrillator <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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2021-22 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 / ^aHaving 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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2021-22 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 Rd.
 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 for details. Holiday hours vary by clinic; call clinic or check online for details.