

MOUNTAINSIDE HIGH SCHOOL

2021-2022 Athletic Clearance Packet

The following forms must be completed and uploaded to RegisterMyAthlete.com and cleared by the MHS Athletic Office **BEFORE** your first practice/tryout each school year.

1. Athletic Emergency/Clearance and Athletic Permission Form with signature of parent/guardian and athlete.
2. Complete and turn in the brain book course. **Each athlete must show proof of medical insurance.** Medical insurance may be purchased if your parent/guardian does not have any. Student Accident Insurance Protection Plan information is available in the office.
3. Read the Release of Liability and Assumption of Risk Form. The form needs the signature of the parent/guardian and athlete.
4. The AIA Physical Examination Packet must be completed by a health professional.
 - a. Physical Evaluation Form should be completed by the parent/guardian.
 - b. Physical Examination Form should be completed by a healthcare professional. The physical must dated March 1st 2021 or later.
 - c. Traumatic Brain Injury Acknowledgement Form must be signed by athlete and parent/guardian.
 - d. Consent To Treat Form must be signed by athlete and parent/guardian.
5. **All athletic fees must be taken care of once the athlete has joined a team.**
6. **The entire packet must be completed PRIOR to tryouts or the first day of practice—NO EXCEPTIONS.**

ALL FORMS WILL BE UPLOADED TO REGISTER MY ATHLETE.

1. Go to www.registermyathlete.com and click LOGIN in the upper right hand corner
2. Click Create Account
3. Enter information and create account
4. Click on Parent button
5. Click on Start/Complete a Registration (left side of screen)
6. Click Start a New Registration
7. Follow the prompts to register a test athlete for a sport. You will need to print and complete all forms. The forms will need to be uploaded to RMA before athlete is cleared for athletic participation.

FOR OFFICE USE ONLY

NAME: _____ GRADE: _____ SPORT(S): _____ PHYSICAL DATE: _____ ALL PAGES: _____

MountainsideHigh School 2021-2022 Athletic Clearance Packet

Please **X** next to all sports the student-athlete may participate in during the school year

FALL SPORTS	WINTER SPORTS	SPRING SPORTS	ALL SEASON SPORTS
<input type="checkbox"/> Football <input type="checkbox"/> Girls Volleyball <input type="checkbox"/> Girls Soccer <input type="checkbox"/> Boys Soccer	<input type="checkbox"/> Wrestling <input type="checkbox"/> Girls Basketball <input type="checkbox"/> Boys Basketball	<input type="checkbox"/> Softball <input type="checkbox"/> Baseball <input type="checkbox"/> Golf	<input type="checkbox"/> Spiritline

STUDENT: _____ BIRTHDATE: _____ SEX: _____ GRADE: _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

PARENT/GUARDIAN NAME: _____ HOME PHONE: _____ CELL PHONE: _____

IN CASE OF EMERGENCY, IF PARENTS CANNOT BE CONTACTED, THE NAME OF A RELATIVE OR CLOSE FRIEND WHO WILL ASSUME RESPONSIBILITY.

NAME: _____ HOME PHONE: _____ CELL PHONE: _____

ATHLETE HAS MEDICAL INSURANCE: YES _____ NO _____ (mark one)

Student athletes must have medical insurance in order to participate in athletics. NADABURG UNIFIED SCHOOL DISTRICT DOES NOT PROVIDE HEALTH INSURANCE FOR STUDENT ATHLETES. NUSD has resources to assist families in obtaining insurance for their student athlete. Please contact the school Athletic Director for information.

The student will continue to be covered during the present school year by an accident/health insurance policy issued by:

INSURANCE COMPANY NAME: _____ POLICY NUMBER: _____

The above mentioned policy will provide adequate and equivalent protections in the event of an injury to the above named students during a school-supervised practice or game.

If emergency service involving medical action or treatment is required and neither parent or guardian can be contacted, I hereby consent for the student named above to be given care.

(Mr./Mrs./Ms.) _____ give permission for (student name) _____ to participate in the sport(s) that I have **X** above. This consent shall endure throughout the school year unless the consent has been withdrawn in writing to the school principal over parental signature.

***Last School attended:** _____

****Please note that this information is required. If you are a transfer from another high school you are required by AIA to complete a 520 form online PRIOR to participating in MHS Athletics. Please visit www.aiaonline.org/520/. Please see the Athletic Director for any questions.**

BRAINBOOK

All athletes are required by the AIA to complete the 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 uploaded with the athletic packet. The website for this course is <http://www.aiaacademy.org/users/login.brainbook>. This course only needs to be completed one time prior to participating.

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.

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.

INSURANCE

By signing this permission form I, the parent/guardian, **agree to provide the insurance for my child.** I will also provide the school with any information that might limit my child's participation in the program.

PRACTICE

Practice will begin after school and will continue until the sport activity bus departs campus around 5:15pm unless communicated differently by the athletic director or coach.

CODE OF CONDUCT/HANDBOOK

Students who participate in the program must obey all rules and regulations of NUSD and are subject to dismissal from the team based on failure to attend practices, maintain adequate academic standards or follow the rules of the Nadaburg Unified School District.

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/daughter's complete name.

PARENT/GUARDIAN SIGNATURE: _____

I/WE have read, understand, and will abide by the statements listed on all pages of this packet.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

STUDENT SIGNATURE: _____ Date: _____

Mountainside High School 2021-2022 Athletic Clearance Packet

Athletic Emergency and Clearance Card

Name: _____ Student ID: _____ Birthdate: _____ Gender: _____ Grade Level: _____

Mailing Address: _____

Parent Contact Information

Father: _____ Home Phone: _____ Cell Phone: _____

Mother: _____ Home Phone: _____ Cell Phone: _____

Guardian: _____ Home Phone: _____ Cell Phone: _____

Preferred Hospital: _____ Phone: _____

Preferred Physician: _____ Phone: _____

In case of emergency, if parents cannot be contacted, please give the name of a relative or close friend who will assume responsibility.

Emergency Contact 1: _____ Relationship: _____ Phone: _____

Emergency Contact 2: _____ Relationship: _____ Phone: _____

Medication allergies: _____

Medical Conditions: _____ Asthma _____ Diabetes (Non- Insulin) _____ Diabetes (Insulin)

_____ Allergies (list) _____ Other _____

ATHLETE INSURANCE INFORMATION

ATHLETE HAS HEALTH INSURANCE: YES _____ NO _____ (mark one)

Student athletes must have medical insurance. NADABURG UNIFIED SCHOOL DISTRICT DOES NOT PROVIDE HEALTH INSURANCE FOR STUDENT ATHLETES. NUSD has resources to assist families in obtaining insurance for their student athlete. Please contact the school Athletic Director for information.

The student will continue to be covered during the present school year by an accident/health insurance policy issued by:

INSURANCE COMPANY NAME: _____

POLICY NUMBER: _____

The above mentioned policy will provide adequate and equivalent protections in the event of an injury to the above named students during a school-supervised practice or game.

If emergency service involving medical action or treatment is required and neither parent or guardian can be contacted, I hereby consent for the student named above to be given care. (Note: Special conditions listed on the back of card)

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Nadaburg Unified School District
Release of Liability and Assumption of Risk Form
Participation in Extra-Curricular School Activities and School Sports Participation Agreement

Read this document fully before signing, this document constitutes a waiver of your legal rights to pursue a claim. By signing this waiver, you are agreeing to waive your rights to pursue a legal claim for and are assuming the risks of injury and damages that incurred while participating in athletics and extra-curricular activities at Nadaburg Unified School District.

I hereby give permission for my child to participate in the following sports program and/or athletic events: _____ at _____. My child and I are familiar with, and knowingly and voluntarily accept, any and all risks associated with participation in the activity. I acknowledge that my child's participation is voluntary and is not part of any regular school curriculum.

Waiver and Release from Liability:

I waive and release Nadaburg Unified School District, it's board, officers, and employees from liability from any and all claims against Nadaburg Unified School District. This includes accidents resulting in personal injury, accidents or illnesses (including death), and property loss from participating in activities, classes, observation, and use of facilities, premises, or equipment.

Assumption of Risks:

By its very nature, competitive athletics may put students in situations which serious, catastrophic, and, perhaps, fatal accidents may occur. Many forms of athletic competition result in violent physical contact among players, the use of equipment, which may result in accidents, strenuous physical exertion, and numerous other exposures to risk or injury. No amount of instruction, precaution, or supervision will totally eliminate all risk of injury.

I have read the previous paragraphs and I fully understand these and other risks that are inherent in the activities made possible by Nadaburg Unified School District. I understand that my child's participation is voluntary and that I knowingly assume all such risks.

Acknowledgement of Understanding:

I have read this Waiver and Release of Liability and fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. This document is for the entire duration of my child's participation in school physical activities and sports at Nadaburg Unified School District.

Parent's (Guardian) signature: _____ Date: _____

Participant's Signature: _____ Date: _____

Student name (please print): _____ School Year: _____



2021-22 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

	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?	_____	

Explain "Yes" Answers Here



2021-22 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"/>

Explain "Yes" Answers Here

COVID-19...

	Y	N
1) Has your child been diagnosed with COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
1a) If yes, is your child still having symptoms from their COVID-19 infection?	<input type="checkbox"/>	<input type="checkbox"/>
2) Was your child hospitalized as a result for complications of COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist) to be cleared to return to sports?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has your child returned back to full participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
6a) Was your child tested for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
7) Did your child receive the COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
7a) What was the manufacturer of the vaccine? _____		
7b) Date of vaccination(s) _____		

Explain "Yes" Answers Here



Family History Questions: Please Tell Me About Any Of The Following In Your Family...

	Y	N		Y	N
1) 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"/>			
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:					
	Y	N		Y	N
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 Student-Athlete

Signature of Parent/Guardian

Date

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

Date



ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
PHONE: (602) 385-3810



The Preferred Urgent
Care of the Arizona
Interscholastic Association

2021-22 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name: _____ Date of Birth: _____
 Age: _____ Sex: _____
 Height: _____ Weight: _____
 % Body Fat (optional): _____ Pulse: _____
 BP: ____ / ____ (____ / ____ / ____)
 Corrected: Y ☐ N ☐
 Vision: R20/____ L20/____
 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



ARIZONA
INTERSCHOLASTIC
ASSOCIATION

OUR STUDENTS, OUR TEAMS . . . OUR FUTURE.

**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: _____



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 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.

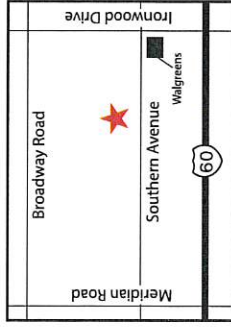
PLEASE PRINT LEGIBLY OR TYPE

"I, _____, the undersigned, am the parent/legal guardian of, _____, a minor and student-athlete at _____ (name of school or district) who intends to participate in interscholastic sports and/or activities.

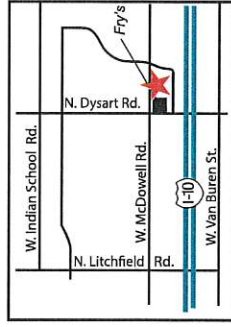
I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities 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 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/AIA.

Date: _____ Signature: _____



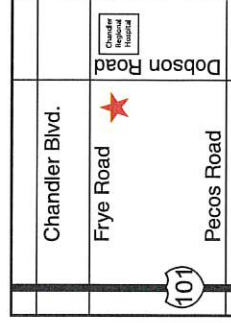
Apache Junction • 85120
2080 West Southern Ave., Suite #A1



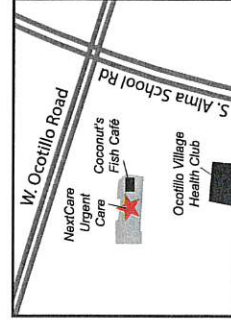
Avondale • 85392
13075 W. McDowell Rd., Suite #D106



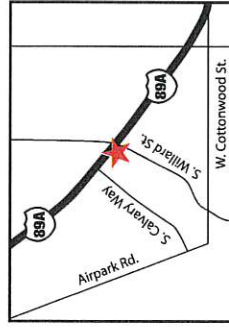
Casa Grande • 85122
1683 E. Florence Blvd., Suite #7



Chandler • 85224
600 S. Dobson Road, Suite #C-26



Chandler • 85248
1155 W. Ocotillo Road, Suite #4



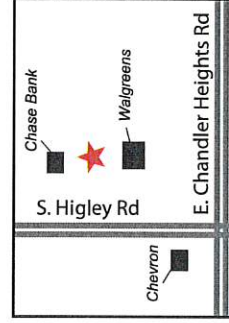
Cottonwood • 86326
450 S. Willard Street, Suite #120



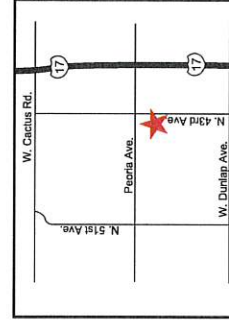
Flagstaff • 86001
1000 N. Humphreys St., Suite #104



Flagstaff • 86001
399 S. Malpais Lane, Suite #100



Gilbert • 85298
6343 S. Higley Road



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



Glendale • 85305
9494 W. Northern Ave., Suite #101



Glendale • 85306
5410 W. Thunderbird Road, Suite #101



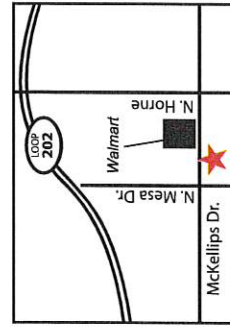
Glendale • 85308
18589 N. 59th Ave., Suite #101



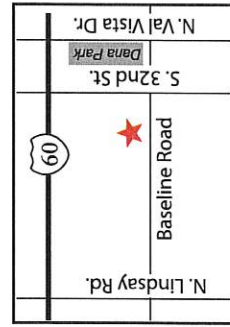
Goodyear • 85338
17688 W. Elliot Road



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



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



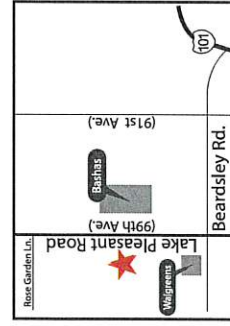
Mesa • 85204
3130 E. Baseline Road, Suite #105



Mesa • 85205
1066 N. Power Road, Suite #101



Nogales • 85621
298 W. Mariposa Road

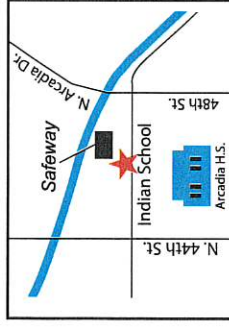


Peoria • 85382
20470 N. Lake Pleasant Rd., Suite #102



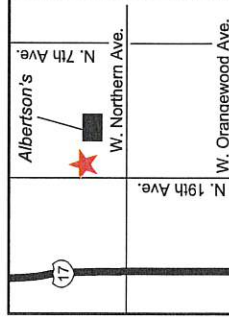
Phoenix • 85016

1701 E. Thomas Road, Suite #A104



Phoenix • 85018

4730 E. Indian School Rd., Suite #211



Phoenix • 85021

8101 N. 19th Ave., Suite #A



Phoenix • 85032

3229 E. Greenway Rd., Suite #102



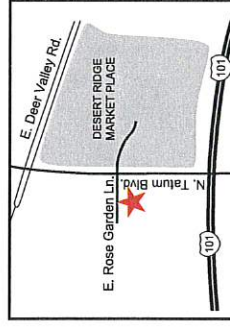
Phoenix • 85018

3931 E. Camelback Road



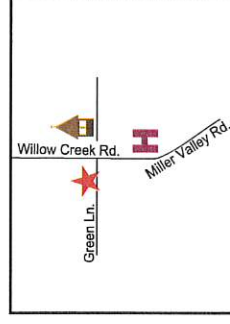
Phoenix • 85035

5920 W. McDowell Road



Phoenix • 85050

20950 N. Tatum Blvd., Suite #190



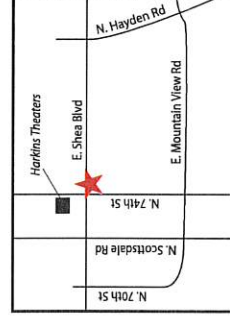
Prescott • 86301

2062 Willow Creek Road



Prescott Valley • 86314

3051 N. Windsong Drive



Scottsdale • 85260

7425 E. Shea Blvd., Suite #108



Scottsdale • 85257

2122 N. Scottsdale Road



Sedona • 86336

2530 W. SR 89A, Suite #A



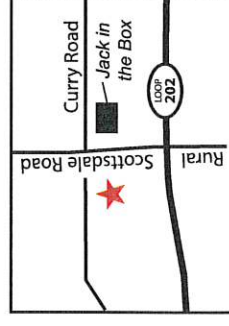
Sun City • 85351

9745 W. Bell Road, Suite #105



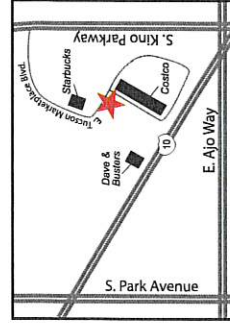
Surprise • 85374

14800 W. Mtn. View Blvd., Suite #100



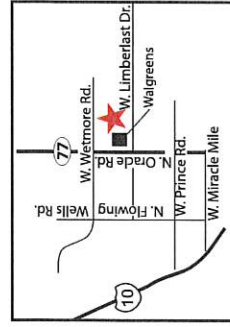
Tempe • 85281

914 N. Scottsdale Rd., Suite #104



Tucson • 85713

1570 E. Tucson Marketplace Blvd.



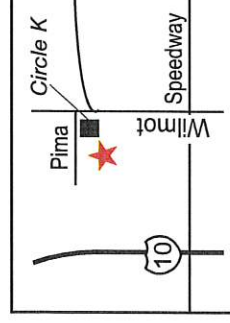
Tucson • 85705

4280 North Oracle Rd., Suite #100



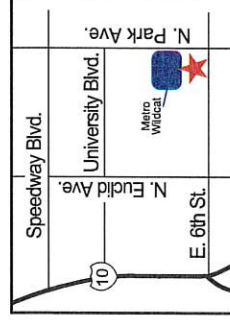
Tucson • 85706

5369 S. Calle Santa Cruz, Suite #145



Tucson • 85712

6238 E. Pima Street

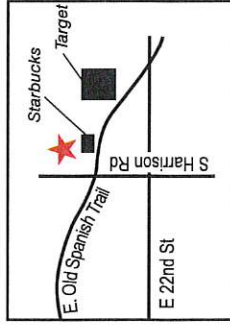


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