Canyon Athletic Association
8102 N. 23rd Ave Suite E Phoenix, AZ 85021
Phone: 602-898-1845 info@azcaa.com

2026 - 2027 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 condition (like diabetes or asthma)?		
3) Are you currently taking any prescription or non-prescription (over the counter) medicines or supplements? (Please specify):		
4) Do you have allergies to medicines, pollen, 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): ☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ 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): ☐ Head ☐ Neck ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm ☐ Hand/Fingers ☐ Chest ☐ Upper Back ☐ Lower Back ☐ Hip ☐ Thigh ☐ Knee ☐ Calf/Shin ☐ Ankle ☐ 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	YES	NO
37) Have you ever had a menstrual period?		
38) How old were you when you had your first menstrual period?		
39) How many periods have you had in the last year?		
EXPLAIN "YES" ANSWERS HERE		
COVID	YES	NO
1) Have you been hospitalized for COVID-19 or any major illness in the past year?		
2) Have you experienced lingering symptoms affecting exercise tolerance?		

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

Student Name: _____ Date of Birth: _____

Mental Health Screening (PHQ-4)	0-3	NA
Over the last 2 weeks, how often have you been bothered by the following problems? (0= Not at all, 1= Several days, 2 = More than half the days, 3 = Nearly every day)		
1) Feeling Nervous, anxious, or on edge		
2) Not being able to stop or control worrying		
3) Little interest or pleasure in doing things		
4) Feeling down, depressed, or hopeless		

Neurological History / Lifestyle & Risk Factors	YES	NO
1) Have you ever had a concussion or head injury?		
2. Do you use tobacco or vaping products?		
3) Do you use alcohol or illegal drugs?		
4) Do you take supplements or performance-enhancing substances?		

EXPLAIN "YES" ANSWERS HERE

Concussion & Athletic Acknowledgement	YES	NO
1) I acknowledge the statement below.		

Statement:

Participation in athletics involves risk of injury, including concussion. I have received information regarding concussion symptoms and reporting. I understand that I must report symptoms immediately. I agree to follow CAA rules, including sportsmanship expectations under CAA governance.

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furtherm ore, 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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2026-2027 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 / &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

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2026-2027 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 il lnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after participating 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 are 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 stu dent-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 safe ty of the minor. I understand that 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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