

(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.

|  |           |            |            |           |         |         |              |       |            |            |     |       |      |           |       |           |  |  |  |  |
|--|-----------|------------|------------|-----------|---------|---------|--------------|-------|------------|------------|-----|-------|------|-----------|-------|-----------|--|--|--|--|
|  | <b>Y</b>  | <b>N</b>   |            |           |         |         |              |       |            |            |     |       |      |           |       |           |  |  |  |  |
| 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?<br>(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):<br>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?  |           |            |            |           |         |         |              |       |            |            |     |       |      |           |       |           |  |  |  |  |
| 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?<br>(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):   |           |            |            |           |         |         |              |       |            |            |     |       |      |           |       |           |  |  |  |  |
| <table border="0" style="width: 100%;"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper Arm</td> <td>Elbow</td> <td>Forearm</td> </tr> <tr> <td>Hand/Fingers</td> <td>Chest</td> <td>Upper Back</td> <td>Lower Back</td> <td>Hip</td> <td>Thigh</td> </tr> <tr> <td>Knee</td> <td>Calf/Shin</td> <td>Ankle</td> <td>Foot/Toes</td> <td></td> <td></td> </tr> </table> | Head      | Neck       | Shoulder   | Upper Arm | Elbow   | Forearm | Hand/Fingers | Chest | Upper Back | Lower Back | Hip | Thigh | Knee | Calf/Shin | Ankle | Foot/Toes |  |  |  |  |
| Head   | Neck      | Shoulder   | Upper Arm  | Elbow     | Forearm |         |              |       |            |            |     |       |      |           |       |           |  |  |  |  |
| Hand/Fingers   | Chest     | Upper Back | Lower Back | Hip       | Thigh   |         |              |       |            |            |     |       |      |           |       |           |  |  |  |  |
| Knee   | Calf/Shin | Ankle      | Foot/Toes  |           |         |         |              |       |            |            |     |       |      |           |       |           |  |  |  |  |

**Y N**

- 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 non-functioning 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?
- 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**

**Explain "Yes" Answers Here**

|  | <b>Y</b> | <b>N</b> |
|--|----------|----------|
| 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?            |          | _____    |

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?
- 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?

### Explain "Yes" Answers Here

### COVID-19...

Y N

- 1) Has your child been diagnosed with COVID-19?  
1a) If yes, is your child still having symptoms from their COVID-19 infection?
- 2) Was your child hospitalized as a result for complications of COVID-19?
- 3) Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)?
- 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?
- 5) Has your child returned back to full participation in sports?
- 6) Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?  
6a) Was your child tested for COVID-19?
- 7) Did your child receive the COVID-19 vaccine?  
7a) What was the manufacturer of the vaccine? \_\_\_\_\_  
7b) Date of vaccination(s) \_\_\_\_\_

### Explain "Yes" Answers Here

**Patient Health Questionnaire Version 4 (PHQ-4)**

Over the last two weeks, how often have you been bothered by any of the following problems? (circle responses)

|   | <b>Not At All</b> | <b>Several Days</b> | <b>Over Half The Days</b> | <b>Nearly Every Day</b> |
|---|-------------------|---------------------|---------------------------|-------------------------|
| Feeling nervous, anxious, or on edge        | 0                 | 1                   | 2                         | 3                       |
| Not being able to stop or control worrying  | 0                 | 1                   | 2                         | 3                       |
| Little interest or pleasure in doing things | 0                 | 1                   | 2                         | 3                       |
| Feeling down, depressed, or hopeless        | 0                 | 1                   | 2                         | 3                       |

*(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)*

If you score a sum of 3 or greater on either questions 1 and 2, or 3 and 4, you may have anxiety or depression that is affecting you more than normal. In this case, it is recommended that you talk to a trusted health care provider such as your primary care physician, your athletic trainer at school, or a counselor at school. If there is not someone you feel comfortable talking to or you are interested in learning more to help yourself or a friend, please use the resources provided below.

For more information regarding student-athlete mental health:  
[Quiet Suffering - A Resource for Student-Athlete Mental Health](https://spark.adobe.com/page/lltwyoLpTAp0V/)  
[spark.adobe.com/page/lltwyoLpTAp0V/](https://spark.adobe.com/page/lltwyoLpTAp0V/)

Teen Lifeline Call and Text Crisis Line  
(602) 248-8336 (TEEN)

Outside Maricopa county call: 1-800-248-8336 (TEEN)

Hours are: Call 24/7/365 | Text weekdays 12-9 p.m. & weekends 3-9 p.m. | Peer counseling 3-9 p.m. daily

Crisis text line: Text HOME to 741741 to connect with a crisis counselor

National Suicide Prevention Lifeline  
1-800-273-8255 or [suicidepreventionlifeline.org](https://suicidepreventionlifeline.org)

The Trevor Lifeline  
866-488-7386 (for gender diverse youth)

**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) |          |          |          |          |
| 2) Are there any family members who died suddenly of "heart problems" before age 50?   |          |          |          |          |
| 3) Are there any family members who have unexplained fainting or seizures?   |          |          |          |          |
| 4) Are there any relatives with certain conditions, such as:   |          |          |          |          |
|  | <b>Y</b> | <b>N</b> | <b>Y</b> | <b>N</b> |
| Enlarged Heart   |          |          |          |          |
| Hypertrophic Cardiomyopathy (HCM)  |          |          |          |          |
| Dilated Cardiomyopathy (DCM)   |          |          |          |          |
| Heart Rhythm Problems  |          |          |          |          |
| Long QT Syndrome (LQTS)  |          |          |          |          |
| Short QT Syndrome  |          |          |          |          |
| Brugada Syndrome   |          |          |          |          |
| Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)   |          |          |          |          |
| Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)   |          |          |          |          |
| Marfan Syndrome (Aortic Rupture)   |          |          |          |          |
| Heart Attack, Age 50 or Younger  |          |          |          |          |
| Pacemaker or Implanted Defibrillator   |          |          |          |          |
| 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.**

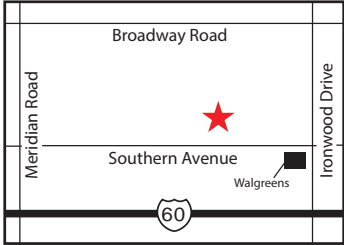
\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Signature of Parent/Guardian

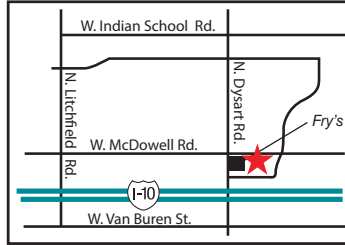
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Date

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

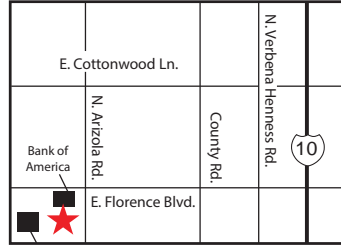
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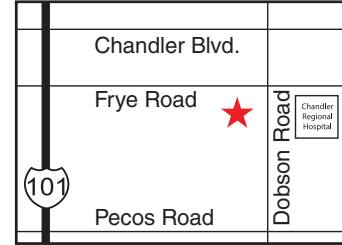
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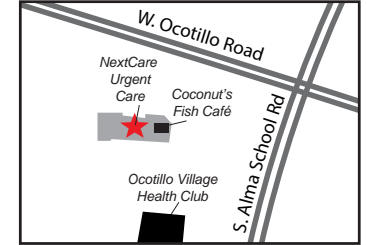
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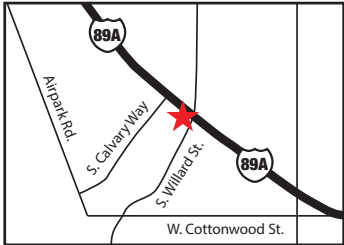
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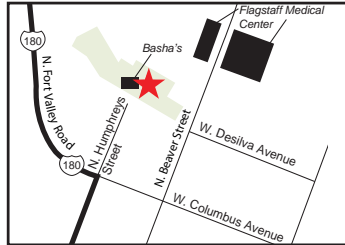
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600 S. Dobson Road, Suite #C-26



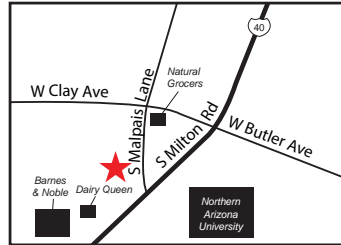
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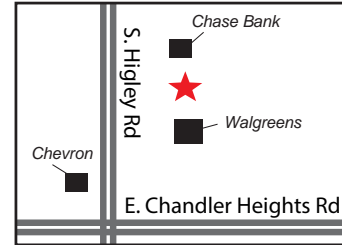
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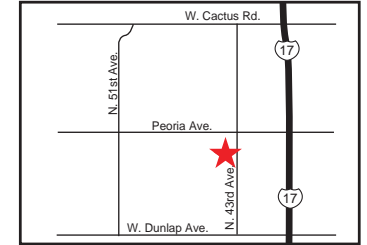
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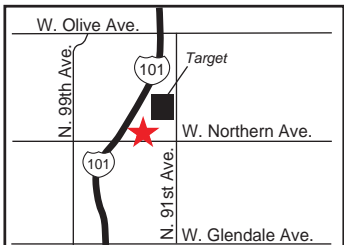
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399 S. Malpais Lane, Suite #100



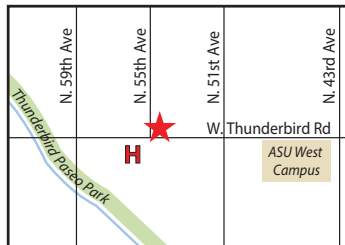
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6343 S. Higley Road



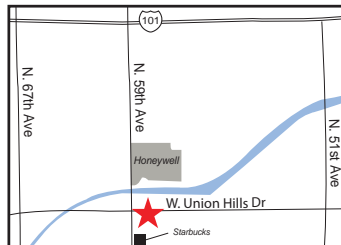
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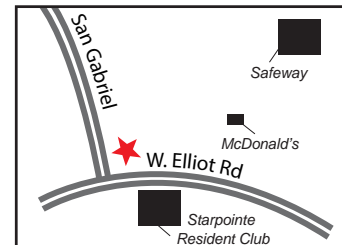
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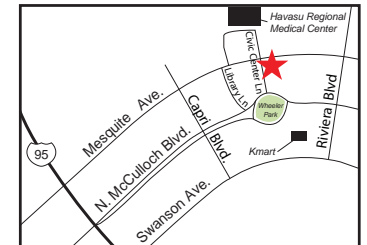
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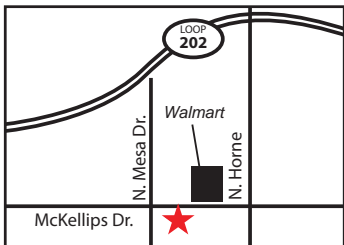
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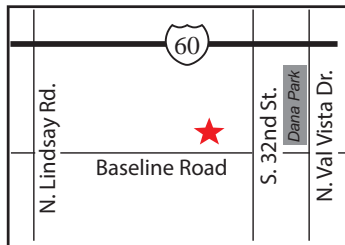
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17688 W. Elliot Road



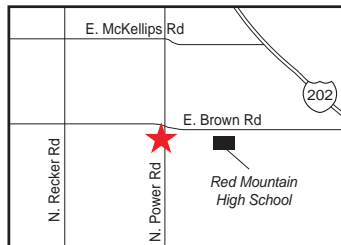
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1810 Mesquite Ave., Suite B



**Mesa • 85203**  
535 E. Mckellips Road, Suite #101



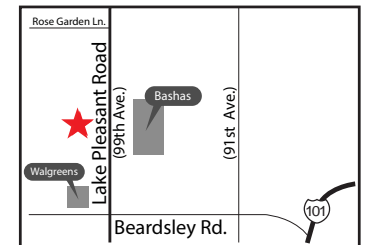
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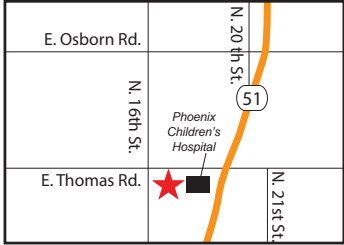
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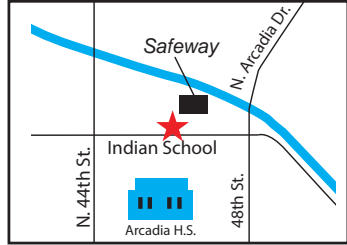
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298 W. Mariposa Road



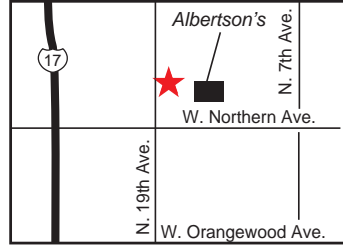
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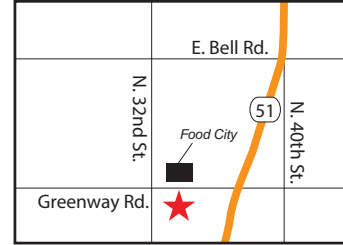
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1701 E. Thomas Road, Suite #A104



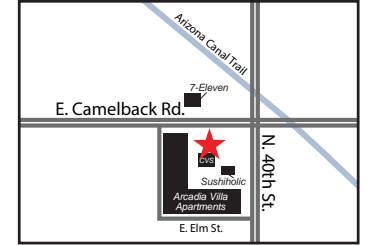
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4730 E. Indian School Rd., Suite #211



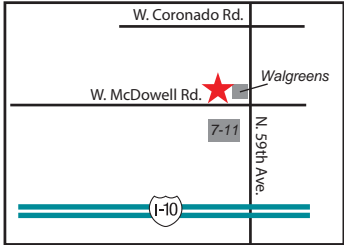
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8101 N. 19th Ave., Suite #A



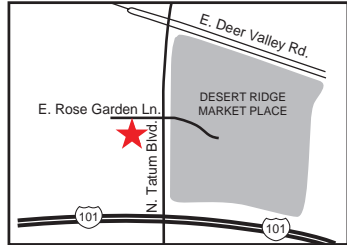
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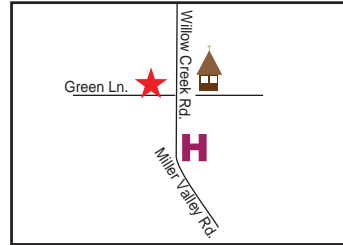
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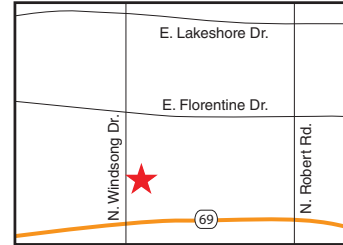
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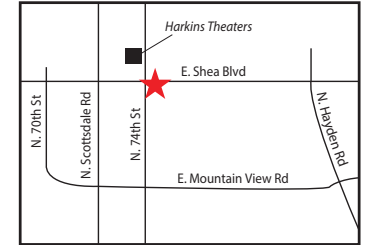
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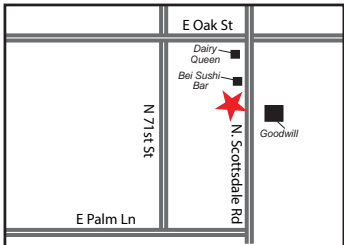
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**Prescott Valley • 86314**  
3051 N. Windsong Drive



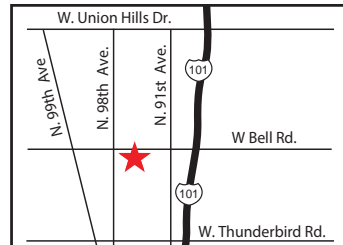
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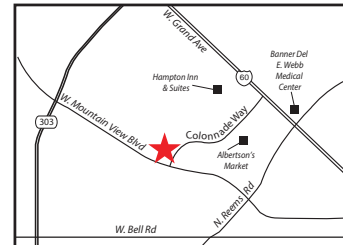
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2122 N. Scottsdale Road



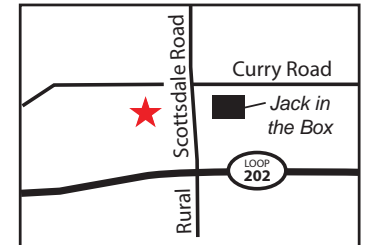
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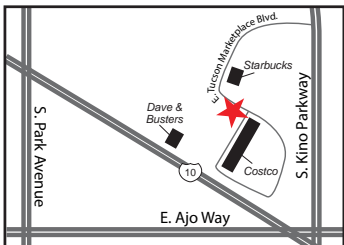
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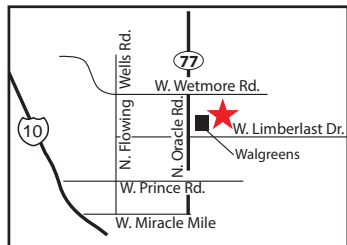
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**Tempe • 85281**  
914 N. Scottsdale Rd., Suite #104



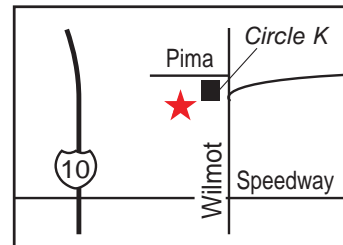
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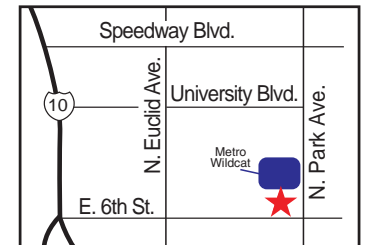
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**Tucson • 85706**  
5369 S. Calle Santa Cruz, Suite #145



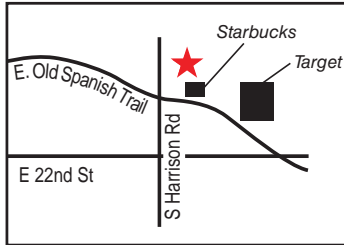
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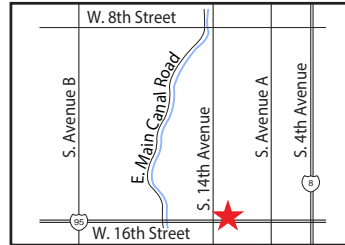
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