BOURGADE CATHOLIC GOLDEN EAGLES
ATHLETICS FORMS CHECKLIST
(FRESHMAN & NEW ATHLETES)

ALL FORMS MUST BE COMPLETED BEFORE PLAYING A SPORT.
ALL DOCUMENTS MUST BE TURNED INTO ATHLETICS.

- AIA ANNUAL PREPARTICIPATION EVALUATION
  (3 PAGES / MUST BE COMPLETED ON AIA FORM 15.7A)

- AIA ANNUAL PREPARTICIPATION EXAMINATION
  (1 PAGE / AIA FORM 15.7B / REQUIRES MEDICAL PROFESSIONAL SIGNATURE)

- AIA MILD TRAUMATIC BRAIN INJURY / CONCUSSION ACKNOWLEDGEMENT FORM **(1 PAGE / AIA FORM 15.7C)**

- AIA CONSENT TO TREAT FORM
  (1 PAGE / AIA FORM 15.7D)

- BOURGADE CATHOLIC CONSENT FORM **(NOTARY NEEDED)**

- DIOCESE OF PHOENIX ATHLETIC PARTICIPATION WAIVER

- AIA BRAINBOOK EDUCATION COURSE
  (Freshman will take this course the first day of PE)
  https://academy.azpreps365.com/
  (COMPLETE ONLINE COURSE AND PRINT CERTIFICATE)

- EMERGENCY CARD
  (STAMPED AND APPROVED BY ATHLETICS ONCE ALL FORMS ARE TURNED IN)

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

2020-21 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?	☐	☐
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): ☐ 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? (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

 NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.

	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 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?	☐	☐
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

	Y	N
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

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

2020-21 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?	☐	☐
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...

		Y	N
8)	Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowing 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:	☐	☐

	Y	N		Y	N
Enlarged Heart	☐	☐	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	☐	☐
Hypertrophic Cardiomyopathy (HCM)	☐	☐	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	☐	☐
Dilated Cardiomyopathy (DCM)	☐	☐	Marfan Syndrome (Aortic Rupture)	☐	☐
Heart Rhythm Problems	☐	☐	Heart Attack, Age 50 or Younger	☐	☐
Long QT Syndrome (LQTS)	☐	☐	Pacemaker or Implanted Defibrillator	☐	☐
Short QT Syndrome	☐	☐	Deaf at Birth	☐	☐
Brugada Syndrome	☐	☐			

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

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

2020-21 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

AIA 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: _____

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

2020-21 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: _____

Golden Eagle Athletics
CONSENT FORM

RISK ACKNOWLEDGEMENT / CONSENT TO PARTICIPATE

(Student's Name) _____wishes to participate in sport (s) in the BOURGADE CATHOLIC HIGH SCHOOL sports program during the student's year(s) **[starting through ending year]** _____. I/We realize that there are risks involved in participating in sports and that I/we attended a school meeting, where these risks were discussed and I/we received an opportunity to have all our questions answered. I/We understand that the risks include a full range of injuries, from minor to severe, from being paralyzed or other serious permanent injuries, to death. I/We realize that neither the protective equipment and padding, the safety rules/procedures of the sport, the coaching instruction received, nor the sports medicine care provided to athletes will guarantee safety or prevent all injuries they might sustain. I/We agree to accept these risks as a condition of participation in sports at BOURGADE CATHOLIC HIGH SCHOOL. I/We also understand that it is our responsibility to inform the coaching staff, the Athletic Trainer, and Athletic Director or Assistant Director of any pre-existing medical condition.
This contract will be binding all years participating in athletics and while the student is enrolled in Bourgade Catholic High School.

Parent Initial here: _____

PARENT/GUARDIAN CODES AND ACTIONS

It is the responsibility of the student and the parent/guardian to read and abide by all the rules and policies of both the Student Handbook and the Athletic Handbook. As a member of the AIA Pursing Victory with Honor, all students and parents/guardians are required to display good sportsmanship at all times. I/We understand that a failure to do so will result in me/us being asked to vacate the area where the BOURGADE CATHOLIC HIGH SCHOOL is participating. I/We, by signing below, are stating that we have read both the Student Handbook and the Athletic Handbook and will abide by all rules stated therein.
This contract will be binding all years participating in athletics and while the student is enrolled in Bourgade Catholic High School.

Parent Initial here: _____

ATHLETIC CONTRACT

I request that Bourgade Catholic High School include:

Student-Athlete Name: _____ Date of Birth: _____ Grade: _____

Sport(s) _____

1. To represent Bourgade Catholic High School in athletic activities approved by the Arizona Interscholastic Association.
2. To accompany any school team of which he/she is a member on any of its local or out of town trips.
3. To receive services from the athletic trainers.
4. I agree not to hold the school or anyone acting in its behalf responsible for any injury occurring to the above-named student in the course of any athletic activities or travel.
5. I have read and agree to abide by the rules, regulations, and procedures contained in the Bourgade Catholic High School Student Athlete Handbook.
6. I am aware that playing or practicing in any sport can be a dangerous activity involving many risks of injury. Certain sports are violent contact sports involving even greater risk of injury.

This contract will be binding all years participating in athletics and while the student is enrolled in Bourgade Catholic High School.

Parent Initial here: _____

GAME TRAVEL RELEASE FORM

This request is for (Student Name) _____, a student participating in sports at Bourgade Catholic High School. I/We are requesting permission for him/her to ride either to the in-season sports event or home from the in-season sports event with his/her parent(s)/guardian (list names): _____ Date: _____. I/We will assume full responsibility for my child once I/we transport him/her to the sporting event or once he/she leaves the in-season sporting event. I/We understand by signing this release form, the Diocese of Phoenix and Bourgade Catholic High School are released from all liability.
This contract will be binding all years participating in athletics and while the student is enrolled in Bourgade Catholic High School

Parent Initial here: _____

****

Parent/Guardian: _____ Date: _____

Signature of Notary _____ Date: _____

State of Arizona County of _____

On (date) _____ (name of signer) _____, personally appeared before me and I verify that he/she is the person who signed the above document.

Notary Seal

THE ROMAN CATHOLIC
DIOCESE OF PHOENIX

Athletic Participation Waiver

Parental Permission and Risk Acknowledgement

I give my permission for _____ to participate in organized interscholastic athletics at _____, realizing that such activity involves the potential for injury and illness, which is inherent in all sports. I acknowledge that even with the best coaching, use of the most advanced protective equipment, proper cleaning and strict observance of rules, injuries and illness are still a possibility. On rare occasions, these injuries and illnesses can be so severe as to result in total disability, paralysis, quadriplegia or even death.

I am aware that my child, by participating in athletics may be exposed to and/or contract the novel COVID-19 virus and other viruses and diseases despite precautions taken to minimize the risk of exposure. I certify that my child is in good health, has no fever or other symptoms of COVID-19, and has no current issues that make it unsafe for my child to participate in athletics, which may not have a medical professional on staff. I will notify the school and not send my child to the athletic activity if my child develops a fever or other symptoms of illness or tests positive for COVID-19. Furthermore, I will not send my child to the athletic activity if my child has knowingly been with someone who shows symptoms of or has been diagnosed with COVID-19 until after a 14 day exposure period has been exhausted for my child with no symptoms. I acknowledge that my child and I are responsible for ensuring that he or she takes any necessary medication, and for avoiding any allergies. In the event of a medical emergency, 911 will be called and I will be responsible for any and all costs of medical treatment. I acknowledge that I have read and understand this warning.

To the fullest extent permitted by law, I hereby agree to waive, release, and discharge any and all claims, causes of action, damages, and rights of any kind against the school, Diocese of Phoenix, its insurers, and all of their respective employees, agents, representatives, and volunteers (the "Released Parties") arising from or relating in any way to any damage, injury, trauma, illness, loss, unwanted contact, harassment, disability, dismemberment, or death that may occur to my child, me, or my household members—whatever the cause—due to my child's participation in the athletic activity.

I further agree not to sue the Released Parties, and to defend and indemnify the Released Parties for all claims, damages, losses, or expenses, including attorneys' fees, if a suit is filed concerning an injury, illness, or death to me, my child, or my household members resulting from participation in the athletic activity.

Parent/Guardian Name (Printed) _____

Parent/Guardian Signature _____ Date _____