

NOGALES HIGH SCHOOL 2023-2024 SPORTS PHYSICAL

What to Include in the Athlete Physical Packet 2023-2024

Steps	Follow these steps check off when complete
Page 1	Choose all sports/clubs that your will participate in for the year!
Page 2	Permission form signed by Student and Parent
Page 3	Health form signed by Doctor -Student and Parent If you answered yes on any question please provide explanation in the appropriate box. 3a, 3b & 3c Page 7
Page 4	Physical Exam signed and dated by Physician dated by March 1 and beyond
Page 5	Mild Traumatic Brain Injury Concussion form signed by Student and Parent
Page 6	Permission form Photos, Videos and Interviews etc., Signed by Parent /Student
	Insurance Card copy front and back every year.
	Birth Certificate (copy) one (1) time in four (4) years.
	Brain Concussion/Opioid Test printed and attached with packet. You only have to take this test one (1) time in four (4) years.

Effective immediately: The AIA Sports Medicine Advisory Committee reviewed a medical group's physical forms that the group wanted to use instead of the AIA physical forms and the committee unanimously decided that the current AIA Pre-Participation Physical Forms (15.7-A and 15.7-B) **must** be used for student athletes' physicals **effective immediately**

The AIA Pre-Participation Forms can be found on the AIA website at <http://www.aiaonline.org/about/forms>. For your convenience, the forms have been developed with the capability to complete the forms online and print them for the appropriate healthcare physician to review.

PLEASE MAKE SURE A PEN IS USED WHEN COMPLETING PACKAGE.

In order to be cleared on the following day all physicals **MUST** be in no later than **12:00** p.m. No Exceptions Please!

15.7 PHYSICAL EXAMINATION RULE

15.7.1 A student shall not be allowed to practice or compete in interscholastic athletics until there is on file with the principal or his/her designee a record of a physical examination performed by a doctor of medicine (M.D.), osteopathic physician (D.O.) or certified registered nurse practitioner (N.P.) licensed to practice, or a certified physician's assistant (PA-C) registered by the Joint Board Of Medical Examiners and the Osteopathic Examiners in Medicine and Surgery. The physical examination for the following school year shall be given on or after March 1. The physical examination card on file shall be signed by one of the aforementioned medical providers and shall state that, in the opinion of the examining provider, the provider did not find any medical reason to disqualify the student from practice or competition in athletic contests. The principal or his/her designee, if deemed advisable, may require a student to be reexamined.

NOTE: In order to assure safe and appropriate physical evaluation of prospective high school athletes, individuals who perform examinations of prospective high school athletes should be licensed health care providers whose education, training and experience assure the ability to assess prospective athletes on a systemic basis. Examiners shall be qualified to perform a complete physical examination, including comprehensive evaluation of the following organ systems: circulatory; respiratory; genito-urinary; neurological; and musculo-skeletal. All such health care providers must be licensed in the United States to prescribe all classes of medications in order to fully understand the impact various pharmaceuticals may have on a prospective athlete. (2/17/92)

Welcome to Nogales High School
Athletics/Activities 2023-2024

NHS Administration and coaches are pleased that you have expressed an interest in our extra curricular program. We offer a wide variety of opportunities for all students to enrich their educational experience on our campus.

Attached you will find the necessary information and required forms for athletic and activity participation. All forms must be filled out completely front and back and signed where specified. This packet must be returned to the administration office before you will be allowed to practice or check out equipment from ANY EXTRA CURRICULAR ACTIVITY AT NHS.

1. The Physical Exam must be **taken every year** for participation in sports, music, band and clubs. Please make arrangements to have a physician or nurse practitioner complete this exam on **AIA Form ONLY**. The physician or nurse practitioner must be licensed to practice in the **United States**. **Note: A new physical examination shall be given on or after March 1st, in order to be valid for the following school year.**
2. All Students who have **NOT** participated in extra-curricular activities before **must submit a copy** of their certified **BIRTH CERTIFICATE**.
3. Students **MUST** have **INSURANCE** to participate. Front and back photocopy of the insurance card is required. If you do not have personal insurance, school insurance forms are available in the administration office.
4. Listed below are the sports, activities and clubs offered at NHS that require this packet to be turned in. Please the sport, sports and club you will participate in for the entire year.
5. **AIA Brain Concussion Test** must be taken if you are participating in any sport/band/mariachi/clubs. A printed copy of the certificate of completion must be attached with this packet. You only have to take this test 1 time in 4 years.

FALL SPORTS Brain Book Test Required	WINTER SPORTS Brain Book Test Required	SPRING SPORTS Brain Book Test Required	FBLA (Future Business Leaders of America)
Band	Basketball Boys	Baseball	Folklorico
Cheers	Basketball Girls	Softball	Geek Squad
Chess	Soccer Boys	Tennis Boys	Jazz
Cross Country Boys	Soccer Girls	Tennis Girls	JSA Jr. Statesman of America
Cross Country Girls	Wrestling	Track Boys	Key Club
Dance		Track Girls	Mariachi
Flags			MESA
Football		OTHER	Science Club
Golf		AFJROTC	Skills Club
Volleyball		Auto Club	Sportsman Club
		Comedy Club	E-Sports

"Pursuing Victory with Honor"

Permission/Verification for Athletics
Nogales Unified School District # 1
Nogales High School
2023-2024

Date this page was completed: <input style="width: 150px;" type="text"/>	Grade: _____	Age: _____
Student Name: _____	School ID#: <input style="width: 100px;" type="text"/>	
Address: _____	City: _____	State: _____ Zip Code: _____

Insurance Information:

This certifies that I/we have individual and/or group insurance coverage for our/my son/daughter through the following insurance company: Photo copy of insurance card front & back

Company Name: _____	Policy Number: _____
School Insurance (check here): _____	Type of Insurance Purchased: _____

Liability Waiver:

I/We understand that any cost for medical expenses will not be paid by the Nogales Unified School District No. 1 and that legally the School District had no financial responsibility if accidents occur to students while taking part in band, clubs and/or sports.

Consent for Emergency Care:

Be it known that I, the undersigned parent or guardian of the above named, do hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment or care to said student as, in the judgment of said doctor or hospital, may be rendered, on any emergency basis, in the event said student should be injured or stricken ill while participating in a interscholastic activity sponsored or sanctioned by Arizona Interscholastic Association, Inc., of which Nogales High School is a member or other activities sponsored by Nogales High School.

It is hereby understood that the consent and authorization hereby given and granted are continuing and are intended by me to extend throughout the current school year.

It is further understood that any expenses incurred will be paid for by the insurance or the parent /guardian of the student. Payment of the expense is NOT school responsibility.

Emergency Contact Name: Phone #:

Parental Consent: I/We give permission to participate in band, club and/or organized athletics, realizing that such activity involves the potential for injury which is inherent in such activities. I/We acknowledge that even with the best supervision and strict observance of rules, injuries are still a possibility. On rare occasions the injuries can be so severe as to result in total disability, paralysis, quadriplegia or even death.

I/We acknowledge that I/We have read and understood this warning.

Parent/Legal Guarding Signature

Student Signature

Cell Phone:

Work Phone:

(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"/>	<input type="checkbox"/>
<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 non-functioning 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

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

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)

	Not At All	Several Days	Over Half The Days	Nearly Every Day
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 ≥ 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/

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

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

AIA

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

2023-24

**ANNUAL PREPARTICIPATION
PHYSICAL EVALUATION**

NextCare
URGENT CARE

EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

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	<input type="checkbox"/>		
Eyes/Ears/Throat/Nose	<input type="checkbox"/>		
Hearing	<input type="checkbox"/>		
Lymph Nodes	<input type="checkbox"/>		
Heart	<input type="checkbox"/>		
Murmurs	<input type="checkbox"/>		
Pulses	<input type="checkbox"/>		
Lungs	<input type="checkbox"/>		
Abdomen	<input type="checkbox"/>		
Genitourinary &	<input type="checkbox"/>		
Skin	<input type="checkbox"/>		
Musculoskeletal			
Neck	<input type="checkbox"/>		
Back	<input type="checkbox"/>		
Shoulder/Arm	<input type="checkbox"/>		
Elbow/Forearm	<input type="checkbox"/>		
Wrist/Hands/Fingers	<input type="checkbox"/>		
Hip/Thigh	<input type="checkbox"/>		
Knee	<input type="checkbox"/>		
Leg/Ankle	<input type="checkbox"/>		
Foot/Toes	<input type="checkbox"/>		

* - 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: _____

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of:

Recommendations: _____

Name of Physician (Print/Type): _____ Exam Date: _____

Address: _____ Phone: _____

Signature of Physician: _____, MD/DO/ND/NMD/NP/PA-C/CCSP

FORM 15.7-B 02/22/2023 (rev.) NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.

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

			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
	Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>		Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>
	Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>		Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>
	Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>		Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>
	Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>		Heart Attack, Age 50 or Younger	<input type="checkbox"/>
	Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>		Pacemaker or Implanted Defibrillator	<input type="checkbox"/>
	Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		Deaf at Birth	<input type="checkbox"/>
	Brugada Syndrome	<input type="checkbox"/>	<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

2023-24 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 designate

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: _____

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: _____

NOGALES HIGH SCHOOL ATHLETICS

Permission Form for Photos, Videos, Interviews, Web Publication and Sale. Nogales High School Athletic parental permission for media use, district broadcast, web or other publication of student's photograph, likeness, and/or voice.

Throughout the year, while participating in athletics/activities at Nogales High School your son /daughter will have photos and videos taken of them that are open to the public and where large group photographs or videos will be taken by the media, contracted photographer and/or school/district staff.

In addition, to the above situations, there may be times the media (newspaper, television, or radio), school district staff, or students may take photographs, audio/videotape students, or interview students individually. The school district may display student pictures, videos and interviews in a variety of ways that reasonably portray programs at Nogales High School. Student photos and Videos may also appear on the district website, thereby making it available to the public.

The school district assumes no responsibility for photographs, audio/videotapes, etc. that may be made by parents or other non-school personnel at public events.

Directions: Check one option below:

 I **GIVE** permission for my child to be photographed, audio/videotaped, or interviewed. I understand that this permission covers all academic, sporting, and yearbook events/activities as related to Nogales High School and may be used by the school in print, video and on the district website.

 I **DO NOT GIVE** permission for my child to be photographed, audio/videotaped, or interviewed for use of public viewing.

Student Name: Date

Parent/Guardian/Custodian Name (Please Print)

Parent/Guardian/Custodian Signature:

Once signed and dated, this form shall remain in effect throughout the student's at Nogales High School and kept on file with the Athletic Director. However, at any time during the school year, you may amend this form only by notifying the Athletic Director in writing of your request.



HIGH SCHOOL UNIFIED SPORTS PARTICIPANT RELEASE



RELEASE FORM MUST BE COMPLETED BY PARENT/GUARDIAN OF STUDENT IN ORDER TO PARTICIPATE IN HIGH SCHOOL UNIFIED SPORTS AT AN AIA MEMBER HIGH SCHOOL. THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED, AND DATED TO BE CONSIDERED VALID

PARTICIPANT NAME First _____ Last _____
D.O.B. ____/____/____ School _____

GENERAL RELEASE: TO BE COMPLETED BY ALL HIGH SCHOOL UNIFIED SPORTS PARTICIPANTS

I am the Parent or Guardian of the high school Unified Sports participant named above and agree to the following:

- 1. Able to Participate.** The participant is physically able to take part in Special Olympics / AIA Unified Sports.
- 2. Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") and the Arizona Interscholastic Association to use the participant's likeness, photo, video, name, voice, and words to promote Special Olympics / AIA Unified Sports and raise funds for Special Olympics / AIA Unified Sports.
- 3. Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to participate with or after a concussion or other injury. The participant may have to get medical care if there is a suspected concussion or other injury. The participant also may have to wait 7 days or more and get permission from a doctor before playing sports again.
- 4. Emergency Care.** If a parent or guardian is unavailable to consent or make medical decisions in an emergency, I authorize Special Olympics and/or the Arizona Interscholastic Association to seek medical care for the participant, unless one of the following boxes is checked:
 - I have a religious or other objection to receiving medical treatment.
 - I do not consent to blood transfusions.
 (If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
- 5. Overnight Stay.** For some events, the participant may stay in a hotel or someone's home. If I have questions, I will ask.
- 6. Health Programs.** If the participant takes part in a Special Olympics health program, I consent to health activities, exams, and treatment for the participant. This should not replace regular health care. I can say no to treatment or anything else any time for the participant.
- 7. Personal Information.** I understand my information may be used and shared by Special Olympics and/or the Arizona Interscholastic Association to:
 - Make sure I am eligible and can participate safely;
 - Run trainings and events and share results;
 - Put my information in a computer system;
 - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
 - Research, share, and respond to needs of Special Olympics athletes (identifying information removed if shared publicly); and
 - Protect health and safety, respond to government requests, and report information required by law.
 I can ask to see and change my information.

As the parent or guardian of the high school Unified Sports participant, I have read and understand this form and have explained the contents to the participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the participant.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

ADDITIONAL UNIFIED PARTNER RELEASE: TO BE COMPLETED BY GENERAL EDUCATION STUDENTS ONLY

Waiver and Liability Release. I understand the risks involved with participation in Special Olympics / AIA Unified Sports activities. I fully accept and assume all such risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. I hereby release and covenant not to sue any Special Olympics organization and/or the Arizona Interscholastic Association, its administrators, directors, agents, volunteers, and employees, and other participants ("Releasees") related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I have read this waiver and release and understand that I have given up substantial rights by signing it. I have signed it freely and without any inducement or assurance and intend it be a complete and unconditional release of all liability to the greatest extent allowed by law. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.

I, the Parent/Guardian of this Unified Partner participant, acknowledge that I have read and understand the additional provisions stated above. By signing below, I agree to these provisions on my own behalf and on behalf of the Unified Partner participant.

Parent/Guardian Signature: _____ Date: _____

NOGALES HIGH SCHOOL 2023-2024 SPORTS PHYSICAL

Brain Concussion Form must be attached with physical paperwork in order to be cleared. Thank you!

1. Log onto computer
2. Go onto (e)internet
3. Type web address

<http://www.aiaacademy.org/users/login>

4. Click on Student Registration (Full name is required)
 - a. (Complete) First Name (no nick names)
 - b. (Complete) Last Name and you Id number after your last name please
 - c. etc.
 - d.
5. Fill out the Student Demographic Information
 - Email address is (optional)
 - Keep information simple
 - Don't use your name more than once
 - Pick sport(s) you will be participating in
 - Use your ID# as your Password
6. Click on Register at bottom of page
7. Use the username and password you just created
8. Login
9. Click on Brain Book and then click NEXT
10. When test is completed, Click on small box (bottom left), then click next, click box and next again.

Brain Concussion Test

Opioid Education

PLEASE MAKE SURE OPIOD EDUCATION IS ALSO COMPLETED.

Print certificate and turn in to Ms. Gastelum with your packet. Thank you!

A Fact Sheet for HIGH SCHOOL ATHLETES

HEADS UP CONCUSSION

WHAT IS A CONCUSSION?

A concussion is a brain injury that affects how your brain works. It can happen when your brain gets bounced around in your skull after a fall or hit to the head.

This sheet has information to help you protect yourself from concussion or other serious brain injury and know what to do if a concussion occurs.

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?



REPORT IT. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. It's up to you to report your symptoms. Your coach and team are relying on you. Plus, you won't play your best if you are not feeling well.



GIVE YOUR BRAIN TIME TO HEAL.

A concussion can make everyday activities, such as going to school, harder. You may need extra help getting back to your normal activities. Be sure to update your parents and doctor about how you are feeling.

WHY SHOULD I TELL MY COACH AND PARENT ABOUT MY SYMPTOMS?

- Playing or practicing with a concussion is dangerous and can lead to a longer recovery.
- While your brain is still healing, you are much more likely to have another concussion. This can put you at risk for a more serious injury to your brain and can even be fatal.



Centers for Disease
Control and Prevention
National Center for Injury
Prevention and Control

GOOD TEAMMATES KNOW:

IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.

HOW CAN I TELL IF I HAVE A CONCUSSION?

You may have a concussion if you have any of these symptoms after a bump, blow, or jolt to the head or body:

-  **Get a headache**
-  **Feel dizzy, sluggish or foggy**
-  **Be bothered by light or noise**
-  **Have double or blurry vision**
-  **Vomit or feel sick to your stomach**
-  **Have trouble focusing or problems remembering**
-  **Feel more emotional or "down"**
-  **Feel confused**
-  **Have problems with sleep**

Concussion symptoms usually show up right away, but you might not notice that something "isn't right" for hours or days. A concussion feels different to each person, so it is important to tell your parents and doctor how you are feeling.

The information provided in this document or through linkages to other sites is not a substitute for medical or professional care. Questions about diagnosis and treatment for concussion should be directed to a physician or other health care provider.

HOW CAN I HELP MY TEAM?



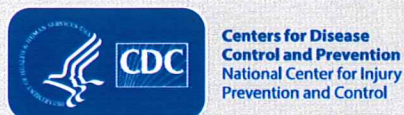
PROTECT YOUR BRAIN.

Avoid hits to the head and follow the rules for safe and fair play to lower your chances of getting a concussion. Ask your coaches for more tips.



BE A TEAM PLAYER.

You play an important role as part of a team. Encourage your teammates to report their symptoms and help them feel comfortable taking the time they need to get better.



To learn more, go to www.cdc.gov/HEADSUP