

Athlete Registration Instructions

If you do not already have an account

1. Go to aktivite.com
2. Click **Login**
3. Then click **Create Account**
4. Fill out all of the information
5. Click **Submit** when finished.

Your account is now created, you will need to complete a registration for your athletes next. After you have completed this step, move on to the next section.

If you already have an account

1. Go to aktivite.com
2. Click **Login**
3. Log in with your email/username and password.
4. Open on the Parent Portal by clicking **Click here to start/complete athlete registrations**
5. Click on **Start/Complete Registrations**. This is on the left-hand side of the screen under the section "what would you like to do?"
6. select **Click Here to Start New Registration**.
7. Click **Select School**
8. Select your school from the list of previously registered schools OR search for your school at the bottom using the state filter and the search bar.
9. Click **Select Athlete**
10. Select an existing athlete and then **Use selected Athlete OR Select Add New Athlete**.
11. Click **Select Year/Sport**

12. Select what academic year your athlete will participate in
13. Select a sport for your athlete and click **Submit**
14. Please review the information carefully before submitting it. Once you have reviewed the information click **I have selected the correct information**

You have now created a registration! Depending on the school, there may be a few additional steps here. Continue to click and complete the red or yellow bars as they appear on the page until you reach the Registration Checklist.

Registration Checklist

This is where documents will be read and agreed to, legally binding E-Signatures will be completed, physicals will be uploaded, and fees can be paid. Once this section is complete, the registration is complete. Any requirements here that require the parent to upload a document will also require that the school's athletic administration approve the document, so please do not be alarmed if the status is Pending School Approval. Your registration is complete once all items on the checklist have been completed.

Additional Athletes: If you have additional student-athletes to register, you can start a new registration and add them as an athlete. **You do not need to create another login for additional athletes.** Once you add them, they will be available to select next time.

Instructional video available at:

<https://aktivate.helpscoutdocs.com/article/38-how-do-i-begin-a-registration-for-a-sport>

Athletic Director/Assistant Principal:

Alex Randel 480-883-5309

Randel.alex@cusd80.com

Administrative Secretary:

Linda Pardoe 480-883-5310

Pardoe.linda@cusd80.com



Crear el Registro de un Estudiante en Aktivate (Register My Athlete)

Si aún no tiene una cuenta

1. Visite la página web aktivate.com
2. Haga clic en **Login**
3. Luego haga clic en **Create Account**
4. Llene toda la información
5. Haga clic en **Submit** cuando haya terminado.

Su cuenta ahora está creada, ahora tendrá que completar el registro de su(s) atleta(s). Continúe con la siguiente sección una vez que haya completado este paso.

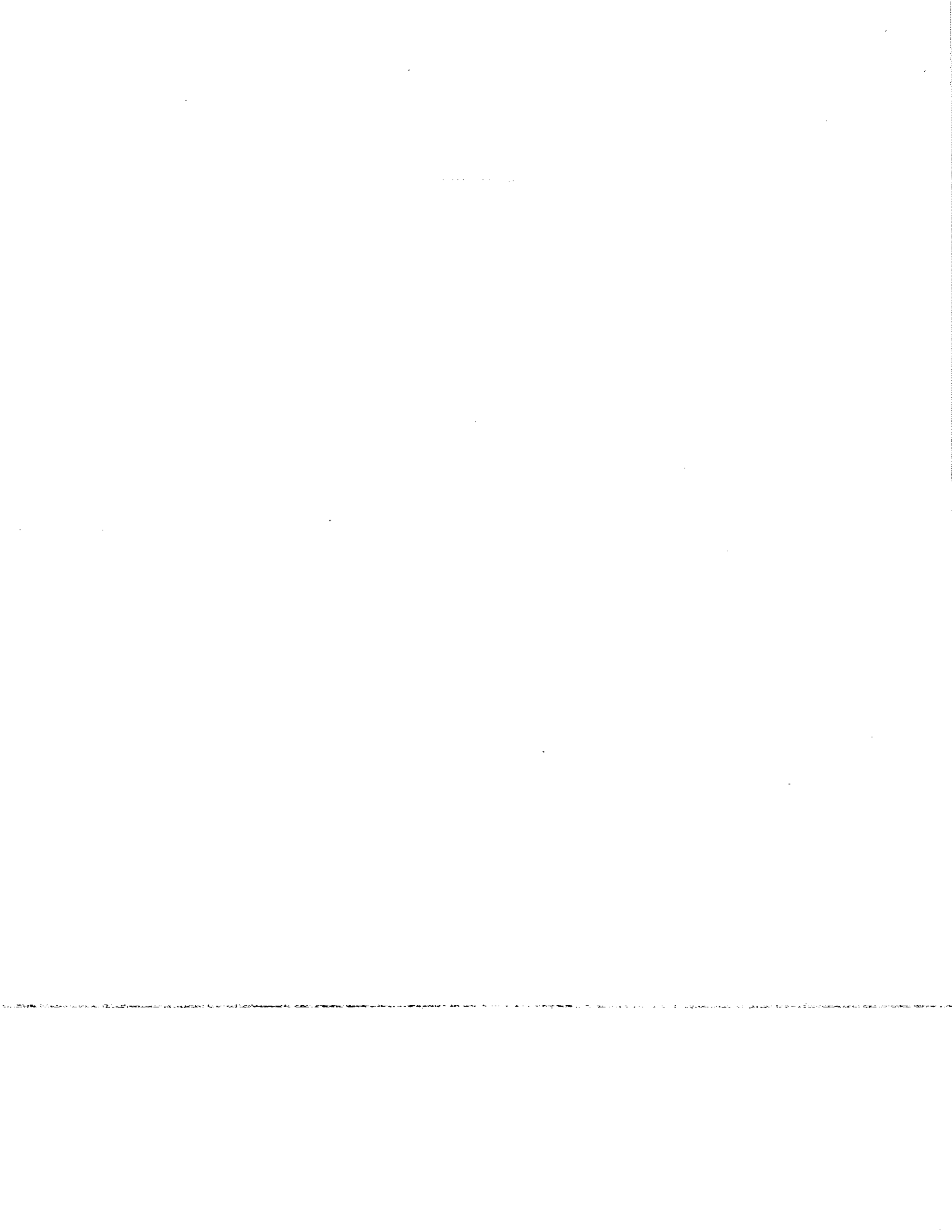
Si ya tiene una cuenta

1. Visite la página web aktivate.com
2. Haga clic en **Login**
3. Inicie una sesión con su correo electrónico/nombre de usuario y contraseña.
4. Abra el Portal de Padres al hacer clic en **Click here to start/complete athlete registrations**
5. Haga clic en **Start/Complete Registrations**. Esto se encuentra en el lado izquierdo de la pantalla abajo de la sección: "what would you like to do?"
6. Seleccione **Click Here to Start New Registration**.
7. Haga clic en **Select School**
8. Seleccione su escuela de la lista de escuelas inscritas anteriormente O OR busque su escuela abajo usando en filtro de estado y la barra de búsqueda.
9. Haga clic en **Select Athlete**
10. Seleccione un atleta existente y luego **Use selected Athlete** O Seleccione **Add New Athlete**.
11. Haga clic en **Select Year/Sport**
12. Seleccione el año académico/escolar en el que participará su atleta
13. Seleccione un deporte para su atleta y haga clic en **Submit**
14. Por favor repase la información cuidadosamente antes de enviarlo. Haga clic en **I have selected the correct information** cuando haya repasado toda la información

¡Ha creado un registro! Puede que haya algunos pasos adicionales, dependiendo de la escuela. Continúe haciendo clic y complete las barras rojas o amarillas conforme vayan apareciendo en su pantalla hasta que llegue al **Registration Checklist** (Lista de Registro).

Registration Checklist – Aquí es donde leerá y coincidirá los documentos, completará las firmas electrónicas que son legalmente vinculante, enviará los exámenes físicos médicos y pagará las cuotas. Su registro está completo después que complete esta sección. Cualquier requisito aquí que requiere que los padres envíen un documento también requieren que la administración atlética escolar apruebe el documento, así que por favor no se preocupe si el estado aparece como **Pending School Approval**. Su registro está completado cuando se haya completado todas las cosas en la lista.

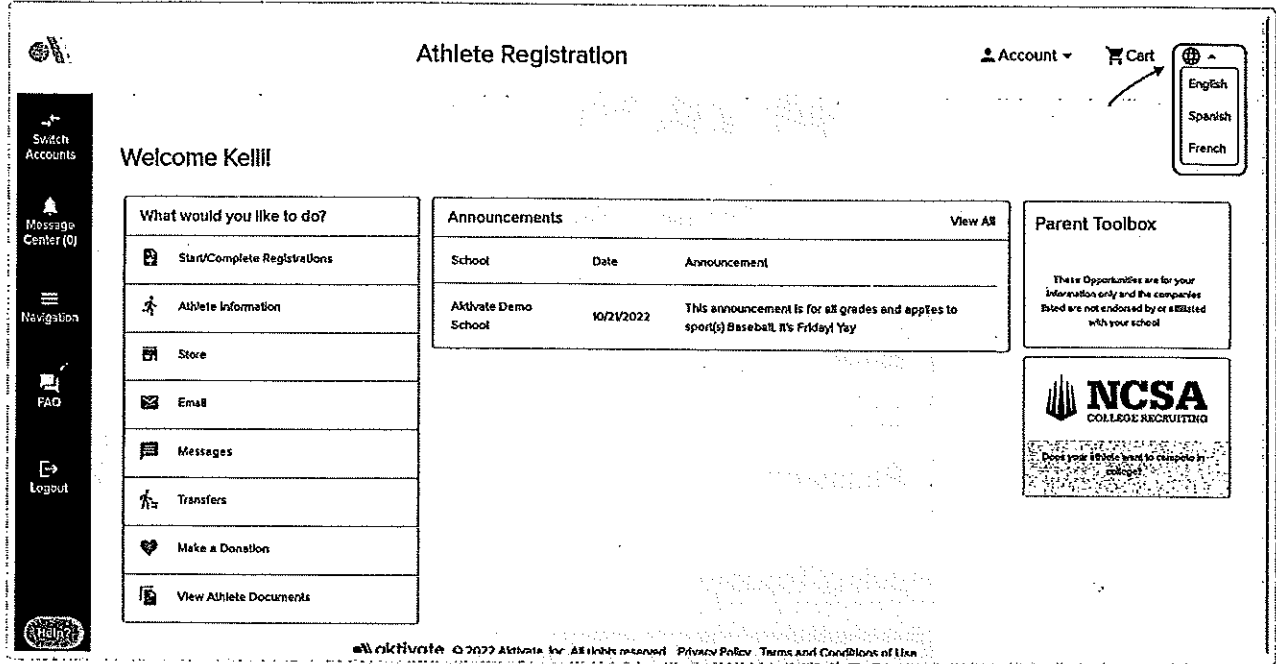
Atletas Adicionales: Si usted tiene estudiantes-atletas adicionales que registrar, puede comenzar un registro nuevo y agregarlos como un atleta. Usted no necesita crear otro nombre de usuario para atletas adicionales. Una vez que los agregue, estarán disponibles para seleccionar la próxima vez.



Language Translation

View in Help Scout (<https://secure.helpscout.net/docs/615caaac2b380503dfdf7a5f/article/637509b5e1486a4bddba7410>)

Akivate now supports language translation in Spanish and French. Once you've created your account and are logged in you can switch the language by clicking on the globe drop down in the top right corner. This will translate the website into the language that you have selected.



If you have any further questions, please reach out to us at support@aktivate.com.

Still need help? Contact Us (#)

Last updated on November 21, 2022

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Help?



Formerly ~~SPORTS~~ ATHLETE.com

Having Trouble?

- › English
- French
- Spanish



English

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

2024-25
ANNUAL PREPARTICIPATION
PHYSICAL EVALUATION

NextCare
URGENT CARE
EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

(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: _____
Sex Assigned at Birth: _____
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) List past and current medical conditions: _____		
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 stinging insects? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection		
7) Have you ever had surgery? (Please list): _____	<input type="checkbox"/>	<input type="checkbox"/>
8) 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 10)	<input type="checkbox"/>	<input type="checkbox"/>
9) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 10):	<input type="checkbox"/>	<input type="checkbox"/>
10) 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		



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EXCLUSIVE URGENT CARE
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	Y	N
11) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
12) 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"/>
13) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
14) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
15) Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
16) Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>
17) Do you have groin or testicular pain, or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
18) 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"/>
19) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
20) Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
21) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
22) 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"/>
23) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
24) 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"/>
25) While exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
26) 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"/>
27) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
28) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
29) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
30) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
31) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
32) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

Females Only

Explain "Yes" Answers Here

	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?	_____	



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2024-25
ANNUAL PREPARTICIPATION
PHYSICAL EVALUATION

NextCare
URGENT CARE
EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

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

Student Name: _____

Date of Birth: _____

Patient History Questions: Please Share 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) Was your child hospitalized as a result for complications of COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child had any long-term complications from COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
3) 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"/>

Explain "Yes" Answers Here



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ANNUAL PREPARTICIPATION
PHYSICAL EVALUATION**



**EXCLUSIVE URGENT CARE
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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)



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ANNUAL PREPARTICIPATION
PHYSICAL EVALUATION



EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

Family History Questions: Please Share About Any Of The Following In Your Family

			Y	N
1) Are there any family members who had sudden/unexpected/unexplained death before age 35? (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 35?			<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:			<input type="checkbox"/>	<input type="checkbox"/>
	Y	N	Y	N
Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" Answers Here

Additional History

	Y	N
1) Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you drink alcohol or use illicit drugs?	<input type="checkbox"/>	<input type="checkbox"/>
3) Have you ever taken anabolic steroids or used any other performance-enhancing supplements?	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever taken any supplements to help you gain or lose weight, or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
5) Do you always wear a seatbelt while in a vehicle?	<input type="checkbox"/>	<input type="checkbox"/>

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



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2024-25
ANNUAL PREPARTICIPATION
PHYSICAL EXAMINATION



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

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: _____



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2024-25

CONSENT TO TREAT FORM



**EXCLUSIVE URGENT CARE
PARTNER OF THE AIA**

2024-25 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: _____