

(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.

	Yes	No
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: _____	<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 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		

	Yes	No
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) Have you or someone in your family tested positive for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
27) Have you been hospitalized or had long-term complication care due to COVID-19?	<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

	Yes	No
33) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
34) How old were you when you had your first menstrual period?	_____	
35) How many periods have you had in the last year?	_____	

Student Name: _____

Date of Birth: _____

Patient History Questions: Please Share About Your Child

	Yes	No
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

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

Share Any Notes Related To The Above Section

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

	Yes	No
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:		
Yes	Yes	No
No		
Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>
Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>
Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack, Age 50 or Younger	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Deaf at Birth	<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" Answers Here

Additional History

	Yes	No
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.

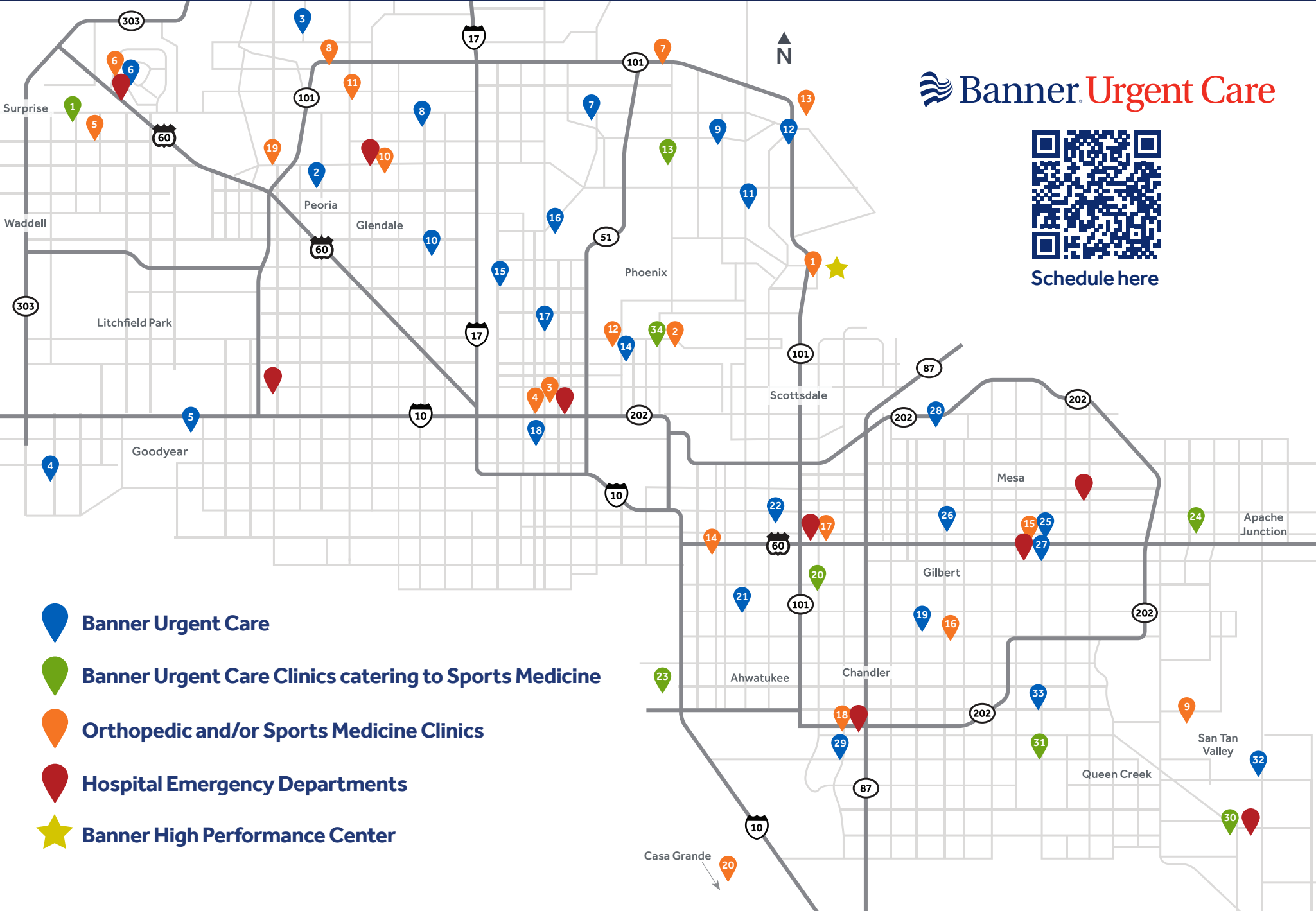
Signature of Student-Athlete

Signature of Parent/Guardian

Date



Schedule here



- Banner Urgent Care
- Banner Urgent Care Clinics catering to Sports Medicine
- Orthopedic and/or Sports Medicine Clinics
- Hospital Emergency Departments
- Banner High Performance Center

Banner Urgent Care

- 1 Bell & Reems**
15521 W. Bell Rd.
Surprise, AZ 85374
- 2 Cactus & 75th Ave.**
7611 W. Cactus Rd.
Peoria, AZ 85381
- 3 Deer Valley & 83rd Ave.**
21980 N. 83rd Ave.
Peoria, AZ 85383
- 4 Yuma & Sarival**
16430 W. Yuma Rd.
Goodyear, AZ 85338
- 5 Van Buren & Avondale**
11685 W. Van Buren St.
Avondale, AZ 85323
- 6 Johnson & Meeker**
13901 W. Meeker Blvd.
Sun City West, AZ 85375
- 7 Bell & 32nd St.**
3247 E. Bell Rd., PB1
Phoenix, AZ 85032
- 8 Bell & 43rd Ave.**
4232 W. Bell Rd.
Glendale, AZ 85308
- 9 Greenway & 64th St.**
6501 E. Greenway Pkwy.
Scottsdale, AZ 85254
- 10 43rd Ave. & Northern**
7952 N. 43rd Ave.
Glendale, AZ 85301
- 11 Scottsdale & Shea**
10330 N. Scottsdale Rd., Ste. 25
Scottsdale, AZ 85253
- 12 Pima & 87th St.**
15223 N. 87th St., Ste. 110
Scottsdale, AZ 85260
- 13 Tatum & Thunderbird**
4760 E. Thunderbird Rd., Ste. 1
Phoenix, AZ 85032
- 14 32nd St. & Indian School**
3141 E. Indian School Rd., Ste. 104
Phoenix, AZ 85016
- 15 19th Ave. & Glendale**
1940 W. Glendale Ave.
Phoenix, AZ 85021
- 16 7th St. & Cave Creek**
9111 N. 7th St.
Phoenix, AZ 85020
- 17 7th St & Camelback**
5018 N. 7th St.
Phoenix, AZ 85014
- 18 Central & Washington**
1 N. Central Ave. Ste. 105
Phoenix, AZ 85004
- 19 Warner & Cooper**
641 W. Warner Rd.
Gilbert, AZ 85233
- 20 Dobson & Guadalupe**
1955 W. Guadalupe Rd., Ste. 1
Mesa, AZ 85202
- 21 Rural & Elliot**
931 E. Elliot Rd., Ste. 115
Tempe, AZ 85284
- 22 McClintock & Southern**
3141 S. McClintock Dr., Ste. 1
Tempe, AZ 85282
- 23 Chandler & 41st St.**
4206 E. Chandler Blvd., Ste. 1
Phoenix, AZ 85048
- 24 Crismon & Southern**
1157 S. Crismon Rd., Ste. 101
Mesa, AZ 85208
- 25 Higley & Southern**
1215 S. Higley Rd.
Mesa, AZ 85206
- 26 Southern & Gilbert**
1121 S. Gilbert Rd., Ste. 101
Mesa, AZ 85204
- 27 Higley & Baseline**
1660 N. Higley Rd., Ste. 104
Gilbert, AZ 85234
- 28 Gilbert & McKellips**
1908 E. McKellips Rd.
Mesa, AZ 85203
- 29 Alma School & Queen Creek**
2950 S. Alma School Rd., Ste. 1
Chandler, AZ 85286
- 30 Gary & Empire**
35945 N. Gary Rd.
San Tan Valley, AZ 85143
- 31 Higley & Queen Creek**
3160 E. Queen Creek Rd.
Gilbert, AZ 85297
- 32 Ironwood & Ocotillo**
40773 N. Ironwood Rd.
San Tan Valley, AZ 85140
- 33 Pecos & Higley**
3126 S. Higley Rd., Ste. 109
Gilbert, AZ 85295
- 34 Arcadia**
4200 E. Camelback Rd., Ste. 106
Phoenix, AZ 85018

 **Banner Urgent Care Clinics**
catering to Sports Medicine

Banner Sports Medicine

Orthopedic and/or Sports Medicine Clinics:

- 1 Banner Sports Medicine Scottsdale**
7400 N. Dobson Rd., 2nd floor
Scottsdale, AZ 85256
480-733-7400
- 2 Banner Health Plus Arcadia**
4200 E. Camelback Rd., 1st floor
Phoenix, AZ 85018
602-229-2200
- 3 Banner University Orthopedic & Sports Medicine**
755 E. McDowell Rd., 2nd floor, Side A
Phoenix, AZ 85006
602-521-3250
- 4 Banner Concussion Center**
1320 N. 10th St., Ste. B
Phoenix, AZ 85006
602-839-7285
- 5 Banner Health Center**
13995 W. Statler Blvd., Ste. 200
Surprise, AZ 85379
623-876-3870
- 6 Banner Health Center**
14416 W. Meeker Blvd.
Sun City West, AZ 85375
623-876-3800
- 7 Banner Health Center**
4375 E. Irma Ln.
Phoenix, AZ 85050
602-298-8888
- 8 Banner Health Center**
7701 W. Aspera Blvd.
Glendale, AZ 85308
602-298-8888
- 9 Banner Health Center**
37100 N. Gantzel Rd., Ste. 107
Queen Creek, AZ 85140
480-394-4480
- 10 Banner Health Clinic**
5601 W. Eugie Ave., Ste. 100
Glendale, AZ 85304
602-298-8888
- 11 TOCA at Banner Health Arrowhead**
18700 N. 64th Dr., Ste. 220
Glendale, AZ 85308
602-277-6211
- 12 TOCA at Banner Health Biltmore**
2222 E. Highland Ave., Ste. 300
Phoenix, AZ 85016
602-277-6211
- 13 TOCA at Banner Health Scottsdale**
9377 E. Bell Rd., Ste. 231
Scottsdale, AZ 85260
602-277-6211
- 14 TOCA at Banner Health Tempe**
5002 S. Mill Ave., Tempe, AZ 85282
602-277-6211
- 15 Banner Health Clinic Gilbert**
1920 N. Higley Rd., Ste. 206
Gilbert, AZ 85234
480-543-6700
- 16 Banner Health Clinic Warner**
155 E. Warner Rd., Gilbert, AZ 85296
480-543-6700
- 17 Banner Health Clinic**
1432 S. Dobson Rd., Ste. 304
Mesa, AZ 85202
480-412-7400
- 18 BMG Health Clinic**
1125 S. Alma School Rd., Se. 210
Chandler, AZ 85286
480-543-6700
- 19 BMG Health Clinic**
9165 W. Thunderbird Rd., Ste. 101
Peoria, AZ 85381
623-876-3870
- 20 BMG Health Clinic**
1811 E. McMurray Blvd.
Casa Grande, AZ 85122
520-374-6520

Banner Urgent Care

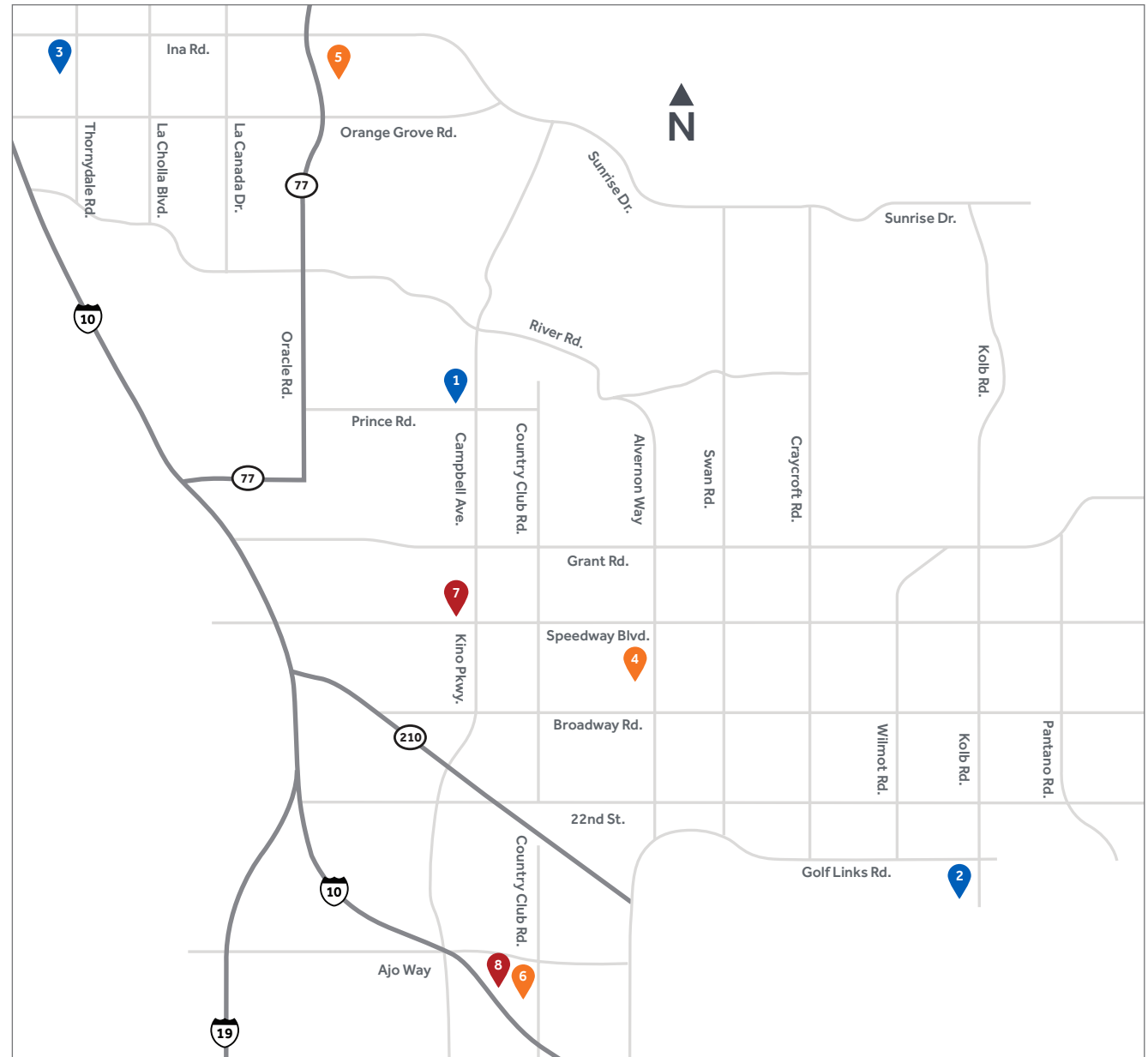
- 1** **Banner Urgent Care** | Prince & Campbell
3611 N. Campbell Ave.
Tucson, AZ 85719
- 2** **Banner Urgent Care** | Golf Links & Kolb
7066 E. Golf Links Rd.
Tucson, AZ 85730
- 3** **Banner Urgent Care Catering to Sports Medicine**
Thornydale & Ina
7089 N. Thornydale Rd., Ste. 101
Tucson, AZ 85741

Orthopedic and/or Sports Medicine Clinics

- 4** **Banner – University Medicine Alvernon Clinic**
707 N. Alvernon Way, Ste. 205
Tucson, AZ 85705
- 5** **Banner – University Medicine North Hills**
265 W. Ina Rd.
Tucson, AZ 85704
- 6** **Banner – University Medicine Center South Campus**
2800 E. Ajo Way, Ste. 200
Tucson, AZ 85713

Hospital Emergency Departments

- 7** **Banner – University Medical Center Tucson**
1625 N. Campbell Ave.
Tucson, AZ 85719
- 8** **Banner – University Medical Center South**
2800 E. Ajo Way
Tucson, AZ 85713



For More Information Regarding Student-Athlete Mental Health

988 SUICIDE & CRISIS
LIFELINE

Athlete Helpline

888•279•1026
athletehelpline.org

Text

Call

Chat

- Athletes
- Coaches
- Parents
- Sports Communities





ARIZONA INTERSCHOLASTIC ASSOC.
OUR STUDENTS, OUR TEAMS ... OUR FUTURE

2026-27

**ANNUAL PREPARTICIPATION
PHYSICAL EXAMINATION**



EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

Name: _____ Date of Birth: _____
 Age: _____ Sex: _____
 Height: _____ Weight: _____ % Body Fat (optional): _____
 Pulse: _____ Blood Pressure (1st measure): ____ / ____ (2nd measure) ____ / ____ (3rd measure) ____ / ____
 Vision: R20/____ L20/____ Corrected: Y N Pupils: Equal Unequal

Medical	Normal	Abnormal
Appearance		
Eyes/Ears/Throat/Nose		
Hearing		
Lymph Nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary&		
Skin		

Musculoskeletal	Normal	Abnormal
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hands/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

A complete PPE requires the information below completed as text or with the official stamp of the provider's office.

* - Multi-examiner set-up only | & - Having a third party present is recommended for the genitourinary examination

NOTES AND RECOMMENDATIONS:

- Cleared without restriction for all sports
- Cleared with the following restrictions and/or recommendations: _____
- Not cleared for any sports [Reason(s)]: _____

Medical Professional has reviewed family history _____ (Initials) Exam Date: _____

Name of Medical Professional (Print/Type): _____

Address: _____

Phone: _____

Signature of Medical Professional: _____

Medical Credential (Circle): MD / DO / ND / NP / PA-C / CCSP

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 ASSOC.
OUR STUDENTS, OUR TEAMS ... OUR FUTURE

2026-27

ANNUAL PREPARTICIPATION

CONSENT TO TREAT FORM



EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

2026-27 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: _____