

**TEMPE UNION HIGH SCHOOL DISTRICT-ATHLETICS/ACTIVITIES REGISTRATION
CLEARANCE PROCEDURE FOR ALL SPORTS-BAND-CHEER**

MAKE SURE YOU ARE IN THE CURRENT SCHOOL YEAR

Register My Athlete streamlines the process of registering students for participation in high school athletics/activities. If you are a returning athlete/student from last school year, go into your RMA portal, verify that all the is correct, then select the sports/activities you will be participating in for the year, do the 5 e-docs and 2 e-signatures, and upload your paperwork.

Instructions for Parents: Please complete all paperwork at least one week prior to try-outs, in order to be cleared on the first day of try-outs. All athletes must have accident or health insurance coverage in order to start the process. Students will not be cleared without insurance. We offer school insurance through Arizona Student Assurance Plans, flyers are available in the athletics office, or you may enroll using online enrollment www.studentinsurance-kk.com. If enrolling online please upload proof of enrollment or bring it to the athletics office.

1. **Find your school:** <http://www.registermyathlete.com/schools/> to access the webpage.
2. **Create an account:** Begin creating your account by clicking the "Create an Account" button. After filling in the required information, the system will automatically log you in and you will be required to accept the terms of use.
3. **Add a new athlete:** The next step is to add an athlete. You can do so by clicking the "**My Athletes**" tab on the left-hand side of the page or by clicking "Add Athlete" underneath the "My Athletes" tab. This only needs to be done once during your athlete's entire career at the same high school. The information entered here will carry over from year to year. This information includes your athlete's contact information and medical information. **If your student is a in or out of state transfer from another high school, make sure you select the transfer when you are adding them as an athlete.**
4. **The Athlete's profile:** After you have created your athlete you will be brought to their profile page. This page is a summary of their info and involvement.
5. **Register for a sport:** Click "Register for a Sport" to begin registration, you will be asked to choose which sport your athlete is registering for. **Select all interested sports for the current school year.**
6. **Your registration checklist:** This page shows the status of your athlete's registration. You will be asked to complete several steps to complete registration, including agreeing to 3 e-documents, 2 e-signatures and completing the physical.
7. **Uploading Forms:** Parents have the ability to down load, print, and up load the documents to the system. Uploaded documents will need to be verified by school administration prior to being accepted as complete. If a document upload is rejected for any reason, the parent will receive an email with the rejection reason. After the error has been corrected, parents will be able to re-upload the entire document for verification. **If you do not have a scanner use your smart phone to log into RMA, take pictures of the forms. When you go to upload it will ask if you want to upload from a PDF or Image, you will select image, go to your photos, click on the form(s) that needs uploaded. When uploading the four page physical packet, you will click on all 4 sheets before uploading.**
8. **Complete registration:** Your registration is complete once all items on the checklist have been completed and verified. **SOME ATHLETES** will also need to take an Impact Test with our school trainer before being cleared. This test is in addition to the Brain Book that EVERY athlete is required to take. **Coaches will receive your clearance info, you do not need to come into the office to pick anything up.**
9. **After registration:** After registration is complete, you can login at any time to view the status of your athlete. **Additional Athletes:** Under the same account, repeat steps 3-9 to register additional Athletes.

****Future Seasons:** Once an athlete has created an account with RMA follow steps 5-8 to register them for another sport in the current year.

Links to form:

Physical packet

<https://www.tempeunion.org/cms/lib/AZ01901094/Centricity/Domain/471/19%2020%20physical%20form%20final.pdf>

Consent to Treat

<https://www.tempeunion.org/cms/lib/AZ01901094/Centricity/Domain/471/19%2020%20Consent%20to%20Treat%20form.pdf>



2019-20 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete)

Exam Date: _____

Name: _____
Home Address: _____
Phone: _____
Date of Birth: _____
Age: _____
Gender: _____
Grade: _____
School: _____
Sport(s): _____
Personal Physician: _____
Hospital Preference: _____

In case of emergency contact:

Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

| | Y | N | | | |
|--|------------------------------------|-------------------------------------|-------------------------------------|--------------------------------|----------------------------------|
| 1) Has a doctor ever denied or restricted your participation in sports for any reason? | <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): High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection <input type="checkbox"/> | | | | | |
| 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 nonfunctioning 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"/> |
| 26) 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"/> |
| 27) While exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28) 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"/> |
| 29) Have you ever been tested for sickle cell trait? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30) Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31) Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32) Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33) Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34) Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35) Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36) Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37) 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 |
|--|--------------------------|--------------------------|
| 38) Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39) How old were you when you had your first menstrual period? | _____ | |
| 40) How many periods have you had in the last year? | _____ | |

2019-20 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

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

Student Name: _____

Date of Birth: _____

Patient History Questions: Please Tell Me About Your Child...

| | Y | N |
|---|--------------------------|--------------------------|
| 1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle? | <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"/> |

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

| | Y | N | | Y | N |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 8) 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"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Are there any family members who died suddenly of "heart problems" before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Are there any family members who have unexplained fainting or seizures? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) Are there any relatives with certain conditions, such as: | | | | | |
| Enlarged Heart | <input type="checkbox"/> | <input type="checkbox"/> | Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertrophic Cardiomyopathy (HCM) | <input type="checkbox"/> | <input type="checkbox"/> | Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) | <input type="checkbox"/> | <input type="checkbox"/> |
| Dilated Cardiomyopathy (DCM) | <input type="checkbox"/> | <input type="checkbox"/> | Marfan Syndrome (Aortic Rupture) | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Rhythm Problems | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack, Age 50 or Younger | <input type="checkbox"/> | <input type="checkbox"/> |
| Long QT Syndrome (LQTS) | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker or Implanted Defibrillator | <input type="checkbox"/> | <input type="checkbox"/> |
| Short QT Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | Deaf at Birth | <input type="checkbox"/> | <input type="checkbox"/> |
| Brugada Syndrome | <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 Athlete _____ Signature of Parent/Guardian _____ Date _____

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP _____ Date _____

2019-20 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

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

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

NOTES:

Cleared Without Restriction
 Cleared With Following Restriction: _____
 Not Cleared For: All Sports Certain Sports: _____ Reason: _____
 Recommendations: _____

Name of Physician (Print/Type): _____ Exam Date: _____
 Address: _____ Phone: _____
 Signature of Physician: _____, MD/DO/ND/NMD/NP/PA-C/CCSP



2019-20 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), Tempe Union High School District (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/AIA, to the extent the QMP deems necessary to prevent harm to the student-athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant or nurse practitioner licensed by the state of Arizona (or the state in which the student-athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by Arizona law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

PLEASE PRINT LEGIBLY OR TYPE

"I, _____, the undersigned, am the parent/legal guardian of, _____, a minor and student-athlete at _____ (name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by Arizona law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/AIA.

Date: _____ Signature: _____

CONSENT FOR EMERGENCY CARE

| | | | |
|---|--------------|---------------|--------|
| Student Name | Student ID # | Date of Birth | Age |
| Parent(s)/Guardian(s) Name | Home # | Cell # | Work # |
| Address | City | Zip | Email |
| Emergency Contact-Person who can answer on your behalf for your child in an emergency | Home# | Cell # | Work# |

If emergency service involving medical action or treatment is required and the parent(s) or guardian(s) cannot be contacted, I hereby consent for the student named to be given medical care by the doctor or hospital selected by the school.

| | | |
|--------------------------|--------------|--------------------------|
| Name of Family Physician | Phone Number | Date of current physical |
|--------------------------|--------------|--------------------------|

STATEMENT OF INSURANCE COVERAGE: (All students MUST have some type of insurance.) Please choose either Option 1 or Option 2.

OPTION 1: I affirm that I am the parent or Legal Guardian of the student signing this form. I request that this student be exempt from the school accident insurance requirements for students participating in athletics and certain other school activities. I represent that this student is currently covered and will be covered during the present school year by an accident insurance policy which provides at least in the equivalent sums and coverage as the policy offered by the school. This includes coverage in the event of injury in a school supervised game or activity.

Company Name _____ Phone # _____ Policy # _____

OPTION 2: I/we desire insurance that will fulfill the school accident insurance requirement.

I have purchased school accident insurance (type) _____ /\$ _____ Effective date: _____ School Official Signature: _____

HEALTH HISTORY: (To be filled out by parent) HAS YOUR CHILD EVER HAD OR NOW HAS: Please circle YES (Y) and/or NO (N)

| Y | N | Allergy | Y | N | Kidney Trouble | Y | N | Diabetes | Y | N | Valley Fever | Y | N | Hepatitis | Y | N | Sprains |
|---|---|---------------------|---|---|--------------------|---|---|------------------|---|---|---------------|---|---|---------------|---|---|-----------------|
| Y | N | Arthritis | Y | N | Migraine Headaches | Y | N | Fainting | Y | N | Heart Trouble | Y | N | Scoliosis | Y | N | Dislocations |
| Y | N | Back Pain | Y | N | Knocked Out | Y | N | Heart Murmur | Y | N | Spine Injury | Y | N | Sinus Trouble | Y | N | Contact Lenses |
| Y | N | Loss Consciousness | Y | N | Concussion | Y | N | Hernia | Y | N | Ankle Injury | Y | N | Operations | Y | N | Tuberculosis |
| Y | N | Eczema (Skin Rash) | Y | N | Sore Throats | Y | N | Menstrual Cramps | Y | N | Neck Injury | Y | N | Fractures | Y | N | Rheumatic Fever |
| Y | N | Epilepsy (Seizures) | Y | N | Anemia | Y | N | Mononucleosis | Y | N | Elbow Injury | Y | N | Hives | Y | N | Asthma |
| Y | N | Chest X-Ray | Y | N | Tetanus Booster | Y | N | Other | | | | | | | | | |

- If YES, give year and details: _____
- Medication (s) now taking: _____ • Medicine(s) student is allergic to: _____
- Does student have to stop while running 1/2 mile? YES NO
- SPORT: FALL: _____ WINTER: _____ SPRING: _____

THIS FORM MUST BE SIGNED BY STUDENT AND PARENT OR LEGAL GUARDIAN

BE IT KNOWN, that, I, the undersigned parent/guardian of the above named student, do hereby give and grant unto any medical doctor, hospital, paramedic or certified school athletic trainer, my consent and authorization to render such aid, treatment or care to said student as, in judgment of said doctor, hospital, paramedic, or certified school athletic trainer, may be required, on an emergency basis, in the event the above-named student should be injured or stricken ill while participating in an interscholastic activity sponsored or sanctioned by Arizona Interscholastic Association, Inc. of which the above named high school is a member.

IT IS HEREBY understood the consent and authorization given are continuing, and are intended throughout the current school year.

IT IS FURTHER understood that insurance or parent of student will pay any expenses incurred. Payment of expense is not a school responsibility. "I/we recognize that the foregoing is a public document and falsification of information on that document to obtain admission to the Tempe Union High School District may constitute violation of the criminals in laws of the State of Arizona. I/we hereby certify that all the information contained in the Tempe Union High School District Athletic Participation Form is true and correct and recognize that in the event that any information in regard to residence has been falsified, I/we will be liable for nonresident tuition from the date of enrollment in the Tempe Union High School District (TUHSD)."

IT IS FURTHER understood that any falsification on this document may result in student losing a year's participation and eligibility in interscholastic athletics in the TUHSD.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implication of signing this document and that I agree to be bound by this document.

| | | |
|-------------------------|-----------------------------|------|
| Student (PRINT) | Student (SIGNATURE) | Date |
| Parent/Guardian (PRINT) | Parent/Guardian (SIGNATURE) | Date |

AIA / NFHS BRAIN BOOK

All student-athletes must complete the Brain Book concussion quiz. Students must pass with at least an 80% or must retake the quiz. Students should print off their certificate indicating they have passed and submit it with their clearance packet. Athletes are only required to complete the Brain Book training once during their four year high school career.

To complete the Concussion Brain Book Quiz:

- 1. Go to www.aiaacademy.org***
- 2. Click on the "Brainbook" link at the top of the page.***
- 3. Click register as a student on the sign in page.***
- 4. Fill out the account creation information and click the appropriate school.***
- 5. Select the sport you are taking the test for and also click any additional sports you may participate in. Then click register.***
- 6. Once registration is complete – log in.***
- 7. Complete the pre-quiz.***
- 8. Athletes must answer all of the questions as they go from page to page through the course.***
- 9. Print out your certificate and submit it to the Athletics Office.***

(Athletes must pass with at least an 80% or must retake the quiz.)