



ATHLETE REGISTRATION INSTRUCTIONS

Register My Athlete gives parents the opportunity to register their student(s) for extracurricular participation at any Peoria Unified School District high school. Please follow the process below to register your student-athlete.

1. Go to www.registermyathlete.com
2. Create an account as the **Parent/Guardian**.
 - a. Complete the required fields.
 - b. Create your password and security questions.
 - c. Click "Create Account"
3. Print: "Account Details" and then click "Got It, I'm Done Here"
4. Accept the Terms of Use and Login
5. Click "Start a New Registration".
 - a. Select the school you plan to attend.
6. Create the Athlete Profile
 - a. Click "Choose Your Athlete".
 - b. Select "Add New Athlete".
 - c. This only needs to be done once during a student's high school career.
 - d. This information will carry over from year-to-year.
 - e. Enter required contact information and medical information.
 - f. Agree to keep all information up to date.
7. Register for a Sport/Activity
 - a. Select the correct school year.
 - b. Choose the sports/activities you wish to participate in.
 - c. Complete the Registration Checklist
 - i. Guardian Information
 - ii. Insurance Information
 - iii. Medical Information
 - d. Complete electronic signatures and documents.
 - e. Upload required documents:
 - i. AIA Physical and PUSD Release of Liability
 - ii. AIA Academy certificates (directions below)
8. Repeat Steps 4 – 6 for additional students.

AIA Academy Courses (both courses only need to be done once for the 4 years of High School)

- Go to AIA website <https://academy.azpreps365.com/>
- Click on the "get started".
- Register as a student – *if already completed print current certificates.*
- Follow the directions as you go through the **Brainbook** and **Opioid** Education course.
- Print or Download certificates and upload to Register My Athlete.

Register My Athlete Technical Support Information

E-mail support: support@registermyathlete.com

Phone support: (435) 213-1601

AIA**ARIZONA INTERSCHOLASTIC ASSOC.**

7007 N. 18TH ST., PHOENIX, AZ 85020

PHONE: (602) 385-3810

2025-26**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.

	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		

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ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

NextCare
URGENT CARE

EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

	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

	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?	_____	

Explain "Yes" Answers Here

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2025-26
ANNUAL PREPARTICIPATION
PHYSICAL EVALUATION

NextCare
URGENT CARE

EXCLUSIVE URGENT CARE
PARTNER OF THE AIA

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

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2025-26

**ANNUAL PREPARTICIPATION
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For More Information Regarding Student-Athlete Mental Health

988 SUICIDE & CRISIS
LIFELINE

Athlete Helpline

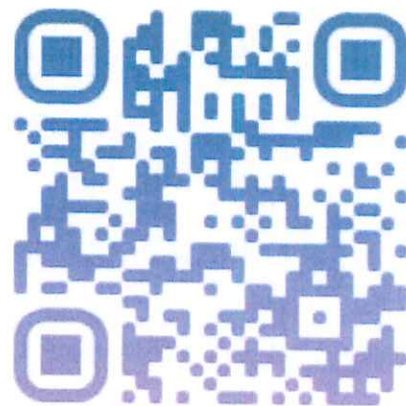
888•279•1026
athletehelpline.org

Text

Call

Chat

- Athletes
- Coaches
- Parents
- Sports Communities



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

	Yes	No		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	No		Yes	No
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

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

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2025-26

ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

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Name: _____ Date of Birth: _____
Age: _____ Sex: _____
Height: _____ Weight: _____
% Body Fat (optional): _____ Pulse: _____
BP: ____ / ____ (____ / ____ / ____)
Corrected: Y N
Vision: R20/____ L20/____
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		
Shouler/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 pf the provider's office.

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

NOTES:

Cleared Without Restriction

Cleared With Following Restriction(s): _____

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 Medical Professional (Print/Type): _____ Exam Date: _____

Address: _____ Phone: _____

Signature of Medical Professional: _____, MD/DO/ND/NP/PA-C/CCSP

Medical Professional has reviewed family history _____ (Initials)

FORM 15.7-B 03/27/2025 (rev.) NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.

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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2025-26**CONSENT TO TREAT FORM**

NextCare
URGENT CARE

**EXCLUSIVE URGENT CARE
 PARTNER OF THE AIA**

2025-26 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: _____



Extra-Curricular School Activities/ School Sports Participation Agreement
RELEASE OF LIABILITY, ASSUMPTION OF THE RISK, COVID 19

Please read this document completely. By signing this waiver, you are assuming the risks of injury and/or damages incurred while your child and you are participating in Athletics and Extra-Curricular Activities at Peoria Unified School District and releasing the Peoria Unified School District from any claims, suits, damages and expenses related thereto.

I hereby acknowledge that my child, if I am signing for them as their legal parent/guardian, or myself, voluntarily desires to participate in athletic (or extra-curricular activities) at "Peoria Unified School District (District). These activities include, without limitation intramural sports, District sponsored events and/or any other sport or activity associated, sponsored or affiliated with the District. I recognize and expressly agree that participating in any sport or activity associated with athletics is an inherently dangerous activity. Further, I recognize that injuries or damages can occur despite the District's best efforts to avoid them and that the District cannot guarantee Participant's Safety.

Waiver and Release from Liability: In consideration of permission to participate in all activities, today and for all future dates I, for myself, my heirs, personal representatives or assigns, do hereby release, waive, discharge, and covenant not to sue the District, its board, officers, employees and agents for any damages, injuries, accidents, illnesses or property loss to myself or others arising from my child's/my participation in activities, classes, observation or use of facilities, premises, or equipment.

Assumption of Risks: There are many risks associated with participation in extra-curricular and/or physical activities. The risks range from minor injuries, such as scratches, bruises, and sprains to major injuries such as eye injury or loss of sight, joint or back injuries, broken bones, concussions and brain injuries to catastrophic injuries including paralysis and death. I hereby acknowledge that my child's, or my participation is voluntary and that I knowingly assume all such risks. I further expressly agree that the foregoing waiver and assumption of risk agreement is intended to be as broad and inclusive as is permitted by the laws of the State of Arizona.

Acknowledgement of Understanding: I have read this Waiver and Release of Liability and fully understand its terms. I acknowledge that I am signing the agreement freely, voluntarily, and intend by my signature, to be a complete and unconditional release of all liability to the greatest extent allowed by law. This document applies for the entire duration of my child's, or my participation in school physical activities and sports at the Peoria Unified School District.

COVID 19: On behalf of myself, my household members, and as parent and lawful guardian of my minor child, I hereby give permission for my child to participate in the Peoria Unified School District camp/clinic/activity. My child and I are familiar with, and knowingly and voluntarily accept any and all risks associated with the camp/clinic/activity on a school campus. I acknowledge that my child's participation in this program is wholly voluntary and is not part of any regular school curriculum. I specifically assume all risks and hazards associated with my child's participation in the camp/clinic/activity including, but not limited to, the risks associated with the COVID-19 or similar type virus. I understand that my child will be associating with staff, volunteers, and other children and may contract COVID-19, and other viruses and diseases, through my child's participation in the camp/clinic/activity. Although the children and staff/volunteers may have their temperatures taken upon entering the facility, that precaution is not nearly adequate to prevent the spread of COVID-19 given, among other things, the relatively long incubation period, and the fact that many infected persons are asymptomatic. I understand and voluntarily assume the risk that my child may acquire COVID-19, and that COVID-19 may subsequently be transmitted from my child to me, my family, and members of my household. I certify that my child is in good health, has no fever, and has no current issues that make it unsafe for my child to participate in camp/clinic/activity, which may not have a medical professional on staff. I will notify the school and not send my child to the camp/clinic/activity if my child develops a fever or illness or tests positive for COVID-19. To the fullest extent permitted by law, I hereby agree to waive, release, and discharge any and all claims, causes of action, damages, and rights of any kind, including serious injury or death, against the Peoria Unified School District, its insurers, the district's governing board, and all of their respective employees, agents, representatives, and volunteers (the "Released Parties") arising from or relating in any way to my child's participation in camp/clinic/activity. Including but not limited to exposure to the COVID-19 virus as we are assuming that risk.

Student (Participants) Name

Participant's Signature

Parent's (Guardian) signature

Date