

2024-2025 Physical Packet Checklist

Submit completed physical packet to the CHS Athletics office

Incomplete packets will not be accepted

Check list of requirements:

___ Brain Book and Opioid Course Certification

*Must be completed by Student-Athlete

___ AIA Physical evaluation packet W/ Concussion Form

*Must be signed by a licensed physician (MD, DO, ND, NMD, NP, PA-C, CCSP)

*Must be signed by Student-Athlete and Parent/Guardian

___ Consent to Treat Form

*Must be signed by Parent/Guardian

___ Coolidge High School Participation Form

*Must be completed with all required information and signed by Parent/Guardian

___ Code of Conduct Form

*Must be signed by Student-Athlete

___ CUSD Transportation Form

*Must be signed by Student-Athlete and Parent/Guardian

___ Eligibility Requirements Form

*Must be signed by Student-Athlete and Parent/Guardian

___ AIA Position Statement and Banned/Illegal Substances Form

*Must be signed by Student-Athlete and Parent/Guardian

___ CUSD Athletics Policies and Procedures Form

*Must be signed by Student-Athlete and Parent/Guardian

All items from the above check list **MUST** be turned into the Athletics Office prior to participation in any activity

Student Signature _____ Date _____

Parent Signature _____ Date _____

Athletics Assistant Signature _____ Date _____

BRAINBOOK & OPIOID COURSES GUIDE

These courses are required by AIA and have to be completed by the student-athlete before being allowed to participate or compete in any sport.

Athletes are only required to complete these courses once while doing sports in HS. If you have done both courses already then just email Ms. MaKenzie that they have been done previously along with the PDF attachment of the completed certificate.

Go to academy.azpreps365.com

Click "Get started" and register for an account

Click "Take course as (your first and last name)"

Register with your school (Coolidge High School) and whichever sports you want to play

Select your language for the Brain book course and then watch the introduction video

Build your player profile and hit submit

Start Level 1 and continue on through the course (It shouldn't take you longer than 1 hour)

Once completion of Brain book is done, please start Opioid course

Select your language and then continue the course (It shouldn't take you any longer than 30-45 minutes)

When finished, email Ms. MaKenzie that you have completed the courses.

If you have any questions, please don't hesitate to ask the athletic department for help!

Email Ms. MaKenzie Blank at
Makenzie.blank@coolidgeschools.org for any athletic questions



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

2024-25
ANNUAL PREPARTICIPATION
PHYSICAL EVALUATION



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		

11) Have you ever had a stress fracture?

12) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?

13) Do you regularly use a brace or assistive device?

14) Has a doctor told you that you have asthma or allergies?

15) Do you cough, wheeze or have difficulty breathing during or after exercise?

16) Have you ever used an inhaler or taken asthma medication?

17) Do you have groin or testicular pain, or a painful bulge or hernia in the groin area?

18) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ?

19) Have you had infectious mononucleosis (mono) within the last month?

20) Do you have any rashes, pressure sores or other skin problems?

21) Have you had a herpes skin infection?

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")?

23) Have you ever had a seizure?

24) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?

25) While exercising in the heat, do you have severe muscle cramps or become ill?

26) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?

27) Have you ever been tested for sickle cell trait?

28) Are you happy with your weight?

29) Are you trying to gain or lose weight?

30) Has anyone recommended you change your weight or eating habits?

31) Do you limit or carefully control what you eat?

32) Do you have any concerns that you would like to discuss with a doctor?

Females Only

37) Have you ever had a menstrual period?

☐ Y
☐ N

38) How old were you when you had your first menstrual period?

39) How many periods have you had in the last year?

Explain "Yes" Answers Here



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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

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
0	1	2	3
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:
spark.adobe.com/page/lltwyolpTAp0V/
 Quiet Suffering - A Resource for Student-Athlete Mental Health

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
 988 or suicidepreventionlifeline.org

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



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

	Y	N		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:					
	Y	N		Y	N
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 35 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

	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 _____

Name: _____ Date of Birth: _____
Age: _____ Sex: _____
Height: _____ Weight: _____
% Body Fat (optional): _____ Pulse: _____
Vision: R20/____ L20/____
Pupils: Equal ☐ Unequal ☐
Corrected: Y ☐ N ☐
BP: ____/____/____ (____/____/____)

Medical	Normal	Abnormal Findings	Initials *
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

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: _____



Coolidge High School

SPORT/ACTIVITY _____

Student's Name _____

Grade _____

Parent/Guardian Permission for Participation in Interscholastic Activities

We/I give consent for _____ to engage in interscholastic athletic competition and other activities for the **2024-2025** school year. We/I realize that participation in organized interscholastic athletics involves the potential for injury that is inherent in all sports. We/I acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observation of rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis, or even death.

WE/I ACKNOWLEDGE THAT WE HAVE READ AND UNDERSTAND THE WARNING

This school district does not carry an accident insurance policy to cover injuries sustained in the interscholastic program. Accident insurance is the responsibility of the parent(s) or guardian(s).

We/I certify that the address and phone numbers listed below are correct. We/I accept the responsibility of notifying the school if the address/phone number should change during the current school year.

We do have medical insurance for the student named above. Yes _____ No _____ Company: _____

Name/Signature of Parent/Guardian _____

Date _____

Home Address _____

Zip Code _____

Home/Cell Phone _____

Emergency/Work Phone _____

INTERSCHOLASTIC EMERGENCY INFORMATION FORM (PLEASE PRINT)

Student Name _____

Age _____

Date of Birth _____

Home Address _____

Zip Code _____

Father's Name _____

Home /Cell _____

Work _____

Email _____

Mother's Name _____

Home/Cell _____

Work _____

Email _____

Guardian _____

Home/Cell _____

Work _____

Email _____

Other individual to notify, if necessary _____

If student is now under medical treatment, why and doctor's name _____

The team Coach may apply emergency treatment until the parent/guardian can be contacted. Yes _____ No _____

We/I give our consent for school officials or coaches to use their judgment in securing aid, transportation, and ambulance service in case the parent/guardian cannot be reached.

Parent/Guardian Signature _____

Date _____

Pursuing Victory with Honor

Code of Conduct for Student-Athletes of Interscholastic Age

Athletic competition of interscholastic age student-athletes should be fun and should also be a significant part of a sound educational program, embodying high standards of ethics and sportsmanship while developing good character and other important life skills. Essential elements of character building are intrinsic in the concept of sportsmanship and six core ethical values: trustworthiness, respect, responsibility, fairness, caring and good citizenship (the "Six Pillars of Character"). The highest potential of sports is achieved when learning from the T.E.A.M. concept (Teach, Enforce, Advocate and Model these values) and be committing to the ideal of pursuing victory with honor. Good-faith efforts to honor the words and spirit of this Code will improve the quality of our programs and the well-being of all teammates.

TRUSTWORTHINESS

- *Trustworthiness* – Be worthy of trust in all you do.
- *Integrity* – Live up to high ideals of ethics and sportsmanship and always pursue victory with honor. Do what's right even when it's unpopular or personally costly.
- *Honesty* – Live and compete honorably. Don't lie, cheat, steal or engage in any other dishonest or unsportsmanlike conduct. Plagiarism or cheating is not acceptable.
- *Reliability* – Fulfill commitments. Do what you say you will do. Be on time to practices and games.
- *Loyalty* – Be loyal to your school and team. Put the team above personal glory.

RESPECT

- *Respect* – Treat all people, including the teacher-coach, with respect at all times. Demonstrate an appropriate demeanor that reflects self-control and an unwavering commitment to fair play.
- *Class* – Live and play with class. Be a good sport. Be gracious in victory and accept defeat with dignity. Help fallen opponents, compliment extraordinary performance, and show sincere respect in pre- and post-game rituals.
- *Disrespectful Conduct* – Don't engage in disrespectful conduct of any sort including profanity, obscene gestures, offensive remarks of a sexual nature, trash-talking, taunting, boastful celebrations, or other actions that demean individuals or the sport.
- *Self-Control* – Exercise self-control. Don't fight or show excessive displays of anger or frustration. Have the strength to overcome the temptation to retaliate.
- *Healthy Lifestyle* – Safeguard your health. Don't use any illegal or unhealthy substances, including alcohol, tobacco, drugs and nutritional supplements, or engage in any unhealthy techniques to gain, lose or maintain weight. Be informed about the health risks involved in the use of recreational and performance-enhancing drugs, tobacco and alcohol, as well as in eating disorders.
- *Sexual Conduct* – Sexual or romantic contact of any sort between student-athletes and adults involved with the program is improper and strictly forbidden. Report misconduct to proper authorities.
- *Respect for Officials* – Treat game officials with respect. Don't complain about or argue with calls or decisions during or after an athletic event. Help youth sports organizations fill their need for qualified officials as a way to promote greater understanding and respect for the referee's role.

RESPONSIBILITY

- *Importance of Education* – The primary responsibility of a student-athlete is academic achievement. Be a student first, and commit to earning your diploma and getting the best education you can. Be honest with yourself about the likelihood of getting an athletic scholarship or playing on a professional level and remember that many universities will not recruit student-athletes who do not have a serious commitment to their education, the ability to succeed academically or the character to represent their institution honorably. Not achieving passing grades will result in your suspension from the team until the deficiency is cured.
- *Role Modeling* – Remember, participation in sports is a privilege, not a right, and that you are expected to represent your school, coach and teammates with honor, on and off the field. Consistently exhibit good character and conduct yourself as a positive role model.

FAIRNESS

- *Fairness and Openness* – Live up to high standards of fair play. Be open-minded, always be willing to listen and learn.

CARING

- *Concern for Others* – Demonstrate concern for others. Never intentionally injure any player or engage in reckless behavior that might cause injury to yourself or others.
- *Teammates* – Help promote the well-being of teammates through positive counseling and encouragement or by reporting any unhealthy or dangerous conduct to coaches.

CITIZENSHIP

- *Playing by the Rules* – Have a thorough knowledge of and abide by all applicable game and competition rules. Demonstrate and demand integrity.
- *Spirit of Rules* – Honor, observe and enforce the spirit and the letter of rules. Avoid temptations to gain competitive advantage through improper gamesmanship techniques that violate the highest traditions of sportsmanship. Do not engage in or allow any conduct designed to evade the rules governing fair competition.

I have read and understand the requirements of this Code of Conduct and acknowledge that I may be disciplined or removed from a team if I violate any of its provisions.

Student-Athlete Signature

Date



ARIZONA INTERSCHOLASTIC ASSOCIATION, INC.
7007 N 18th Street, Phoenix, Arizona 85020-5552
Phone: (602) 385-3810

AIA POSITION STATEMENT

SUPPLEMENTS, DRUGS AND PERFORMANCE ENHANCING SUBSTANCES

PURPOSE OF FORM: All AIA Member schools are required to ANNUALLY communicate this AIA Position Statement on the use of supplements, drugs and performance enhancing substances to every participant in interscholastic activities. (See Article 14, Section 13, Paragraph 2).

The Arizona Interscholastic Association (AIA) views sport, and the participation of student-athletes in sports, as an activity that enhances the student-athlete's well-being by providing an environment and stimulus that promotes growth and development along a healthy and ethically based path.

- It is the position of the AIA that a balanced diet, providing sufficient calories, is optimal for meeting the nutritional needs of the growing student-athlete.
- It is the position of the AIA that nutritional supplements are rarely, if ever, needed to replace a healthy diet.
- Nutritional supplement use for specific medical conditions may be given individual consideration.
- The AIA is strongly opposed to "doping", defined as those substances and procedures listed on the World Anti-Doping Agency's Prohibited List (www.wada-ama.org).
- It is the position of the AIA that there is no place for the use of recreational drugs, alcohol or tobacco (e-cigarettes) in the lifestyle of the student-athlete. The legal consequences for the use of these products by a student-athlete are supported by the AIA.

In pursuit of **Victory with Honor**, the AIA promotes the use of exercise and sport as a mechanism to establish current fitness and long-term healthy lifetime behaviors. It is the position of the AIA that the student-athlete, who consumes a balanced diet, practices sport frequently and consistently, and perseveres in the face of challenges, can meet these goals.

Student-Athlete Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Banned/Illegal Substances

Distributing, selling, possessing or being under the influence of such substances are subject to disciplinary action by the school as well as by the athletic department. The athletic policy is enforceable for any offense occurring during the athletic calendar year, or at any school sponsored off-season activity/event. Substances include but are not limited to:

- Tobacco and tobacco products, including electronic “E” cigarettes;
- Alcohol;
- Illegal drugs (usually classified as dangerous or narcotic);
- Imitation controlled substances;
- Prescription drugs (not prescribed by the student’s physician or distribution or sale of a student’s personal prescription drugs);
- Steroids;
- Drug paraphernalia.

The following are the minimum penalties and/or stipulations for any violation of this policy. At their discretion, coaches and/or the athletic director may require additional conditions in order for a student to regain eligibility. Self-reporting of the above mentioned violations may result in a reduction of consequences.

First Offense

- Loss of 25% of all regular season competition days. Suspensions may include regular season, tournament, invitational, or post-season play. (Ex - If your sport has 20 regular season competition days, a 1st offense violation would result in a minimum loss of 5 competitive days.) Tournament competition days will be counted by the number of guaranteed game days.
- Stipulations will be determined by the Athletic Director and Head Coach of the respective activity. These stipulations may include, but are not limited to, any of the following:
 - Personal accountability
 - Community service
 - Counseling/treatment program
 - Random drug testing (At Family Expense and done by professional organization)
 - Loss of eligibility for school recognized post season awards
 - Dismissal from the program

Second Offense

- Loss of eligibility to participate for one calendar year.
- Stipulations as prescribed above in order to regain eligibility after the completion of the suspension.

Athlete Signature

Date

Parent/Guardian Signature

Date

