

CHARTER SCHOOLS

Preparing Students for the Future
www.aplusaz.org

A+ Charter School Athletics Packet 2023-2024

Name: _____ Graduation Year: _____

Grade _____ Age _____ DOB _____ Gender: _____

Sport(s): _____ Short/pant size: _____ Shirt Size: _____

A student will **not** be eligible to participate (games, practices, tryouts) in any sport without clearance from the Athletic Department. **ALL MATERIALS MUST BE COMPLETED AND RETURNED TO THE ATHLETIC DIRECTOR OR OFFICE.** Students must complete all paperwork and meet all eligibility requirements to participate in sports at A+ Charter School.

- ☐ Parent Consent and Emergency Information
- ☐ Code of Conduct
- ☐ Participation Physical Evaluation - Medical History
- ☐ Participation Physical Evaluation - Physical Examination by a Doctor
- ☐ Athletic Participation / Fee Form
- ☐ Sports Fee (paid in the office) JH- \$75, HS-\$125
- ☐ CAA Concussion Video/ Proof of Insurance

- Student-Athletes will not be eligible to complete until a completed athletic packet, athletics physical have been turned in to the athletic director and sports fee has been paid.
- Fill out all documents and scan and send to Michaela Reese (mreese@aplusaz.org) or drop off hard copies to the front office.

New to A+ Charter School: Y__ N__

Enrollment Date: (__ / __ / __)

Last School Attended: _____

Did you play a sport at a previous school? (Which one(s)? When?)

A+ CHARTER PARENT CONSENT AND EMERGENCY INFORMATION

My signature below indicates my permission for my student, _____, to participate in after school sports/activities at A+ Charter School. My signature also indicates that I have read and approved the medical treatment authorization.

Emergency Information

Student Name: _____ Birthdate: _____ Age: _____

Father's Name: _____ Mother's Name: _____

Day Phone of Parents: Father _____ Mother: _____

Address: _____

Family Doctor: _____ Phone Number: _____

Allergies: _____

In case of an emergency, if parents cannot be reached, please contact:

Name: _____ Phone Number: _____

Medical Treatment Authorization

In the event of illness or injury occurring to my child while participating in this activity, I hereby give my consent for medical or dental care deemed necessary by the attending health care provider or dentist. My child may be examined and any necessary procedures (medical, dental, or surgical), anesthesia or diagnostic procedures (lab or ex-ray) may be performed under the supervision of a member of the hospital or medical office staff furnishing such services.

I understand that, in the event of other than minor illness or injury, reasonable effort will be made to contact me.

I understand that there is inherent risk in many activities, and I hold A+ Charter School harmless and not liable for injury or accident, which may occur in the course of such activities. I willingly and ultimately assume the risk of such injury or accident.

Parent/Guardian Name: _____

Signature: _____ Date: _____

Athletic Participation/Fee Form

Student Name: _____ Grade: _____

I understand that A+ Charter Schools are not insuring my student under any health or accident insurance program, and that my student's participation is covered only under whatever insurance program I have in place. I further understand that A+ Charter Schools disclaims any financial responsibility for the costs of medical treatment, hospitals, ambulances, paramedics, etc. arising out of or by virtue of any injury to my student while participating in interscholastic sports.

Fees used towards the ECA tax credit cannot be refunded. Fees for all sports are due before the first game. Players who have not paid their sports fees will not be allowed to participate in practices or games until the fee is paid. All Athletic Packet paperwork, current sports physicals, concussion certificate and fees are due for the current sport by _____.

Participation on an athletic team at A+ Charter School is a privilege. The Athletic Department reserves the right not to drop any athlete out of the program if they see it necessary without a refund. Game uniforms/jerseys are only to be worn on game/meet days under the coach's decision.

This sports fee is to cover the duration of the league's sports season(s) only. As long as there are enough student-athletes registered and cleared to participate in a particular sport, The A+ Charter Athletic Department will make every effort to provide quality coaching during the season of play.

Fee for unreturned uniforms/jerseys/equipment: A minimum fee of \$150 will be assessed for any uniforms and jerseys which are not returned at the conclusion of the sports season and the fee may be higher for player equipment which is checked out to the athlete at the beginning of the season and not returned at the conclusion of the season. The equipment fee will depend on the cost to replace the piece(s) of equipment.

Parent/Guardian Signature _____ **Date:** _____

In addition to my approval for participation in interscholastic or intramural sports, I understand that the payment of a participation fee is necessary for A+ Charter to continue offering a worthy sports program. The payment fee does not guarantee that my athlete will participate in every or any scheduled competition. I understand that the participation fee allows my student to take part as a member of the team either at the interscholastic level or intramural level. I further understand that if my student withdraws prior to the first game, one half of the participation fee will be refunded. However, athletes who quit or are injured after the first game, are not academically eligible to participate or are dismissed for disciplinary reasons at any time will have no portion of the participation fee refunded.

TRANSPORTATION PERMISSION SLIP

This permission slip is intended to cover A+ Charter student-athletes that ride on A+ Charter provided transportation. This transportation allows a relief to parents from the burden of transporting their students to games and events.

My student-athlete, _____, has my permission to be transported to and from A+ Charter games and events on A+ Charter provided transportation. I understand that such transportation may be in rented cars, vans, private vehicles, and/or chartered buses. It is understood that every necessary precaution will be taken to ensure students' safety. Beyond this, I agree to hold A+ Charter School harmless in the event of any injury to my student-athlete while s/he is participating in off campus activities.

Parent/Guardian Name: _____ Phone: _____

Signature: _____ Date: _____

STUDENT DRIVING/RIDING IN PRIVATE VEHICLE

Transportation to and from activities may be provided by private vehicle or walking. I understand that in some cases students may be driving their own vehicles to and from games, practices, or other A+ Charter events. In the event that alternative private transportation is used in lieu of transportation provided by A+ Charter School, A+ Charter School has no responsibility for the conduct of the driver/vehicle and has no responsibility for ensuring that the driver of the vehicle has accurate insurance and/or license.

In the event that a student-athlete uses alternative or private transportation, I agree to one of the following:

- ☐ I give my permission for my son/daughter to drive a private vehicle to and from activity.
- ☐ I give my permission for _____ to ride in a private vehicle driven by
(Riding Student's Name)
_____ to and from activity.
(Driving Parent's Name)

Parent/Guardian Signature Name: _____ Phone: _____

Signature: _____ Date: _____

Note: Before any student-athlete is permitted to participate in A+ Charter Schools activities requiring school transportation, this permission form must be signed and returned. NO EXCEPTIONS.

CAA CONCUSSION

This is to confirm that I have watched and completed the Concussion in Sports training video required by A+ Charter School and the CAA (Canyon Athletic Association). This is necessary in order for the athlete named below to participate in any competitive sporting events offered through the CAA. This must be completed annually.

<https://www.nfhslearn.com/courses/61059/concussion-for-students>

Athlete's Name: _____ Date: _____

Completion Date: _____ Completion Code: _____
(found on the certificate) (found on the certificate)

* Please bring in a printed copy of the certificate or an email version to mreese@aplusaz.org.

PROOF OF MEDICAL INSURANCE FORM

Proof of Health/Accident/Hospitalization Insurance

Name of Insurance Company: _____

Address of Insurance Company: _____

Policy Number: _____

Group Number: _____

Other policy Identifying Number(s): _____

Name of Insured: _____

Relationship to student: _____

Expiration Date or terms regarding when coverage will cease: _____

I hereby certify that the above information is complete and accurate to the best of knowledge. I understand that if any of this information is to change I must notify A+ Charter School to update my students file.

Name of Student (please print): _____

Parent's Signature: _____ Date: _____

Emergency Contact Form

Student Name _____

Student Address _____

Parent/Legal Guardian Name _____

Address (if different from above) _____

Home Phone Number _____ Work Phone Number _____

Cell/Pager Number _____ Work Phone Number _____

Email Address _____

Emergency Contact Name _____

Emergency Contact Phone _____ Relationship to Student _____

Family Doctor Name _____ Phone _____

Hospital Preference _____ Phone Number _____



Canyon Athletic Association
2033 W. North Lane Suite #19 Phoenix, AZ 85021
Phone: 602-687-1645 info@azcaa.com

HONORHEALTH



The Preferred Urgent Care of the Canyon Athletic Association

2023-24 SCHOOL YEAR, ANNUAL PRE-PARTICIPATION PHYSICAL EVALUATION

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

Name: _____

Home Address: _____

Phone/s: _____

Date of Birth: _____ Age: _____ Gender: _____ Grade: _____

School: _____ Sport(s): _____

Personal Physician: _____

Hospital Preference: _____

EMERGENCY CONTACTS

1) Name		Relationship
Phone (Home):	Phone (Work):	Phone (Cell):
2) 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?		
2) Do you have an ongoing medical conditional (like diabetes or asthma)?		
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify):		
4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify):		
5) Does your heart race or skip beats during exercise?		
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 spent the night in a hospital?		
8) Have you ever had surgery?		



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Explain "Yes" answers on the following page. Circle questions you don't know the answers to.	YES	NO
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)		
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11):		
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): <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Head</div> <div style="width: 33%;"><input type="checkbox"/> Neck</div> <div style="width: 33%;"><input type="checkbox"/> Shoulder</div> <div style="width: 33%;"><input type="checkbox"/> Upper Arm</div> <div style="width: 33%;"><input type="checkbox"/> Elbow</div> <div style="width: 33%;"><input type="checkbox"/> Forearm</div> <div style="width: 33%;"><input type="checkbox"/> Hand/Fingers</div> <div style="width: 33%;"><input type="checkbox"/> Chest</div> <div style="width: 33%;"><input type="checkbox"/> Upper Back</div> <div style="width: 33%;"><input type="checkbox"/> Lower Back</div> <div style="width: 33%;"><input type="checkbox"/> Hip</div> <div style="width: 33%;"><input type="checkbox"/> Thigh</div> <div style="width: 33%;"><input type="checkbox"/> Knee</div> <div style="width: 33%;"><input type="checkbox"/> Calf/Shin</div> <div style="width: 33%;"><input type="checkbox"/> Ankle</div> <div style="width: 33%;"><input type="checkbox"/> Foot/Toes</div> </div>		
12) Have you ever had a stress fracture?		
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?		
14) Do you regularly use a brace or assistive device?		
15) Has a doctor told you that you have asthma or allergies?		
16) Do you cough, wheeze or have difficulty breathing during or after exercise?		
17) Is there anyone in your family who has asthma?		
18) Have you ever used an inhaler or taken asthma medication?		
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?		
20) Have you had infectious mononucleosis (mono) within the last month?		
21) Do you have any rashes, pressure sores or other skin problems?		
22) Have you had a herpes skin infection?		
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")?		
24) Have you ever had a seizure?		
25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?		



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Explain "Yes" answers on the following page. Circle questions you don't know the answers to.	YES	NO
26) While exercising in the heat, do you have severe muscle cramps or become ill?		
27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
28) Have you ever been tested for sickle cell trait?		
29) Have you had any problems with your eyes or vision?		
30) Do you wear glasses or contact lenses?		
31) Do you wear protective eyewear, such as goggles or a face shield?		
32) Are you happy with your weight?		
33) Are you trying to gain or lose weight?		
34) Has anyone recommended you change your weight or eating habits?		
35) Do you limit or carefully control what you eat?		
36) Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	YES	NO
37) Have you ever had a menstrual period?		
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		
COVID	YES	NO
1) Has your child been diagnosed with COVID-19? 1a) If yes, is your child having any symptoms from their COVID-19 infection?		
2) Was your child hospitalized as a result from complications of COVID-19?		
3) Has your child been diagnosed with Multi-inflammatory Syndrome in Children (MIS-C)?		
4) Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist)?		
5) Has your child returned back to full participation in sports?		
6) Has your child direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?		
7) Did you child receive the COVID-19 vaccine? 7a) What was the manufacturer of the vaccine? _____ 7b) Date of vaccination(s) _____		



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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...		YES	NO
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?			
2) Has your child ever had extreme shortness of breath during exercise?			
3) Has your child had extreme fatigue associated with exercise (different from other children)?			
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?			
5) Has a doctor ever ordered a test for your child's heart?			
6) Has your child ever been diagnosed with an unexplained seizure disorder?			
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?			
Family History Questions: Please Tell Me About Any Of The Following In Your Family...		YES	NO
8) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowning or near drowning)			
9) Are there any family members who died suddenly of "heart problems" before age 50?			
10) Are there any family members who have unexplained fainting or seizures?			
11) Are there any relatives with certain conditions, such as:			
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Enlarged Heart <input type="checkbox"/> Hypertrophic Cardiomyopathy (HCM) <input type="checkbox"/> Dilated Cardiomyopathy (DCM) <input type="checkbox"/> Heart Rhythm Problems <input type="checkbox"/> Long QT Syndrome (LQTS) <input type="checkbox"/> Short QT Syndrome <input type="checkbox"/> Brugada Syndrome <input type="checkbox"/> Catecholaminergic Polymorphic Ventricular </div> <div> <input type="checkbox"/> Tachycardia (CPVT) <input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) <input type="checkbox"/> Marfan Syndrome (Aortic Rupture) <input type="checkbox"/> Heart Attack, Age 50 or Younger <input type="checkbox"/> Pacemaker or Implanted Defibrillator <input type="checkbox"/> Deaf at Birth </div> </div>			
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 _____



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HONORHEALTH



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2023-24 **SCHOOL YEAR,** **ANNUAL PRE-PARTICIPATION PHYSICAL EXAMINATION**

Name: _____

Date of Birth: _____ Age: _____ Gender _____ Height _____ Weight _____

% Body Fat (optional): _____

Pulse: _____ BP: _____ / _____ (_____ / _____ / _____)

Vision: R20/ _____ L20/ _____ Pupils: ☐ Equal ☐ Unequal Corrected: ☐ Yes ☐ No

	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



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2023-24 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 Canyon Athletic Association (CAA), _____
(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/CAA, 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, 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.

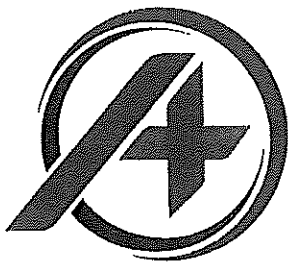
PLEASE PRINT LEGIBLY OR TYPE

"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/CAA 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/CAA.

Date: _____ Signature: _____



CHARTER SCHOOLS

Preparing Students for the Future

www.aplusaz.org

Extracurricular Tax Credit Contribution Form

Extracurricular activities for students are optional, noncredit educational activities that supplement education. A **tax credit** is a dollar-for-dollar reduction in the actual tax owed to the State of Arizona. It reduces your tax liability by the amount you donate, up to \$400 for married couples and \$200 for singles.

Please choose a campus:

- ☐ **A+ Charter Schools - Maricopa (7-12)**
- ☐ **Undesignated:** Use where needed most

Contributor Information

First Name	Last Name	Phone
Street Address		
City, State Zip	E-mail	

Contribution Designation

\$ _____ I wish to designate this money for:

- ☐ General Extracurricular Activities, including Sports - direct as needed
- ☐ College and Business Tours
- ☐ Specific Eligible Activities (list below):

\$ _____

\$ _____

\$ _____

☐ Specific Student: Student Name(s): _____

Method of Payment:

Please make checks payable to **A+ Charter Schools**. Contributions received on or before December 31 will be eligible for a tax credit on Arizona State Taxes. Visit www.aplusaz.org to pay securely online by Visa, Mastercard OR Paypal. This is a secure website. You will receive confirmation and a receipt. **Please return this form to the campus.**

- ☐ Cash
- ☐ Check # _____
- ☐ Money Order
- ☐ Online Payment: Date _____ Confirmation Number _____

Name: _____ Signature: _____ Date: _____

Name: _____ Signature: _____ Date: _____

Office Use Only

Date Received _____ Received by _____ Total Received _____

The above contribution is eligible for the Arizona state income tax credit as allowed by Arizona Revised Statute §43-1089.01. The tax credit is limited to \$200 for a single individual or \$400 for a married couple. A receipt will be mailed to you for tax purposes. Contributions are nonrefundable by school district. Please consult your personal tax advisor to determine the application of the credit.

