

FORM B -- NIAA PRE-PARTICIPATION HISTORY FORM

HISTORY	DATE OF EXAM: _____
NAME: _____	SEX: _____ AGE: _____ D.O.B.: _____
GRADE: _____	SCHOOL: _____ SPORT(S): _____
ADDRESS: _____	PHONE: _____
PERSONAL PHYSICIAN: _____	
IN CASE OF EMERGENCY, CONTACT - NAME: _____	
RELATIONSHIP: _____	PHONE (H): _____ (W): _____

**EXPLAIN "YES" ANSWERS BELOW.
CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.**

	YES	NO
1. Do you have a chronic medical condition (asthma, diabetes, high blood pressure, etc.)?	_____	_____
2. Have you ever been hospitalized overnight?	_____	_____
3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	_____	_____
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	_____	_____
5. a. Have you passed out or been dizzy during exercise?	_____	_____
b. Have you had chest pain (or pressure) with exercise?	_____	_____
c. Have you had excessive unexplained shortness of breath or fatigue with exercise?	_____	_____
d. Is there a family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50?	_____	_____
e. Is there any history in your family of hypertropic cardiomyopathy, dilated cardiomyopathy long QT syndrome or Marfan's syndrome?	_____	_____
f. Has a physician denied or restricted your participation in sports for any heart problem?	_____	_____
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	_____	_____
7. a. Have you had a head injury or concussion?	_____	_____
b. Have you been knocked out, become unconscious, or lost your memory?	_____	_____
c. Have you had a seizure?	_____	_____
d. Do you have frequent or severe headaches?	_____	_____
e. Have you had numbness or tingling in your arms, hands, legs, or feet?	_____	_____
8. Have you become ill from exercising in the heat?	_____	_____
9. Do you cough, wheeze, or have trouble breathing during or after activity?	_____	_____

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|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------|
| | | YES | NO |
| 10. | a. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | _____ | _____ |
| | b. Are you missing an eye, kidney, testicle or ovary? | _____ | _____ |
| 11. | a. Have you had any problems with your eyes or vision? | _____ | _____ |
| | b. Do you wear glasses, contacts, or protective eyewear? | _____ | _____ |
| 12. | a. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints? | _____ | _____ |

b. *If yes, check appropriate item and explain below.*

- | | | |
|-----------------|-----------------|-----------------|
| _____ Head | _____ Elbow | _____ Hip |
| _____ Neck | _____ Forearm | _____ Thigh |
| _____ Back | _____ Wrist | _____ Knee |
| _____ Chest | _____ Hand | _____ Shin/Calf |
| _____ Shoulder | _____ Finger(s) | _____ Ankle |
| _____ Upper Arm | _____ Foot | _____ Toe(s) |

13. Are you actively trying to gain or lose weight? _____

14. Would you like to talk to someone about stress, anger, depression or other issues? _____

15. Record the dates of your most recent immunizations (shots) for:

Tetanus _____	Mcasles _____
Hepatitis B _____	Chickenpox _____

FEMALES ONLY

16. When was your first menstrual period? _____
- When was your most recent menstrual period? _____
- How much time do you usually have from the start of one period to the start of another? _____
- How many periods have you had in the last year? _____
- What was the longest time between periods in the last year? _____

EXPLAIN "YES" ANSWERS HERE: _____

Name of physician (print/type): _____ Phone: _____

Address: _____
 Street City State Zip Code

I, _____ hereby certify that I am a licensed _____, and have reviewed the information in this FORM B prior to conducting a physical examination for the assigned student.

Signature of Health Practitioner	License Number	Office Phone Number	Date
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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete	Signature of Parent/Guardian	Date
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FORM C

Dear Health Practitioner;

Enclosed is the revised Nevada Interscholastic Activities Association (NIAA) packet for High School Pre-participation Physical Evaluations (PPE's). You will notice that the form we are using incorporates recommendations from the Second PPE Task Force (1997)(supported by the AAFP, AAP, AMSSM, AOSM and AOASM) and separately from the AHA. We anticipate that this form will be reviewed every few years and we will keep you apprised of any changes. Also, for young athletes with known cardiovascular abnormalities, we recommend following the guidelines of the 26th Bethesda Conference. We recommend you reference the Task Force monograph, the AHA recommendations or the 26th Bethesda Conference before performing high school athletic physicals in Nevada.

While many of you have been performing these evaluations for years, we would like to bring your attention to a few points. As discussed in the introduction to the monograph, there are multiple reasons for performing PPE's; the foremost reasons are to prevent injury and sudden cardiac death.

It is estimated that between 1 and 2 deaths (predominantly cardiovascular in etiology) per 200,000 high school athletes occur per year. The prevalence of cardiovascular disease capable of causing sudden cardiac death in these athletes is around 1/20,000. The most common cause of cardiac death in this population is hypertrophic cardiomyopathy (HCM).

Since the vast majority of PPE's will be completely normal, and, conversely, most students with abnormalities on history or physical exam do NOT have significant cardiac pathology, extreme diligence is required when performing these exams so that the few students with serious conditions are not missed.

ANSWERS ON THE HISTORY FORM THAT WOULD SUGGEST A NEED FOR A CARDIOLOGY CONSULTATION INCLUDE:

- Excessive shortness of breath, syncope or chest pain during exercise.
- Family history of premature death or cardiovascular morbidity. (Before age 50)
- Family history of HCM, dilated cardiomyopathy, long QT syndrome, or Marfan's syndrome.

ABNORMALITIES ON THE PHYSICAL EXAM THAT SUGGEST THE NEED FOR ECHOCARDIOGRAPHY OR CARDIAC CONSULTATION INCLUDE:

- Any systolic murmur greater than II/VI.
- Any diastolic murmur.
- A murmur that increases in intensity from supine to standing (suggests HCM).
- Stigmata of Marfan's syndrome. (Attachment 7).

A second goal of the PPE is to detect chronic illnesses or old injuries that may hamper the athlete's performance (such as Exercise Induced Asthma) or lead to injury ("the most common cause of injury is reinjury").

The final goal of the PPE is to provide our young athletes with a chance to talk to a physician about health issues. While this exam does not replace ongoing care by a personal physician, it may be the only contact these students have. Therefore, a brief discussion of health issues such as breast and testicular cancer screening, alcohol and tobacco use, automobile safety, etc., may be appropriate during the PPE.

Thank you for your willingness to help ensure a safer future for Nevada's young athletes.

Published by the NIAA Sports Medicine Advisory Committee.

Approved: February 2000; June 2012

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References:

- 26th Bethesda Conference: Recommendations for Determining Eligibility for Competition in Athletes with Cardiovascular Abnormalities. JACC. 1994;24(4):845-99.
- Corrado D, Basso C, Schiavon M and Thiene G. Screening for Hypertrophic Cardiomyopathy in Young Adults. NEJM. 1998;339(6):364-9.
- Epstein SE, Maron BJ. Sudden death and the competitive athlete: Perspectives on pre-participation screening studies. J Am Coll Cardiol 7:220-230, 1986.
- Maron BJ, Thompson PD, Puffer JC, et al. Cardiovascular preparticipation screening in competitive athletes. Circ. 94:850-856, 1996.
- Glover DW, Maron BJ. Profile of preparticipation cardiovascular screening in high school athletes. JAMA. 279:1817-1819. 1998.
- Pelliccia A and Maron BJ. Preparticipation Cardiovascular Evaluation of the Competitive Athlete: Perspectives from the 30-Year Italian Experience. Am J Cardiol. 7(41)15/95:827-9.
- Preparticipation Physical Evaluation, 2nd ed. AAFP, AAP, AMSSM, AOSM, AOASM. McGraw-Hill. 1992.
- Smith J and Laskowski ER. The Preparticipation Physical Examination: Mayo Clinic Experience with 2,739 Examinations. Mayo Clin Proc. 1998;73:419-29.
- Liberthson R. Sudden Death from Cardiac Causes in Children and Young Adults. Current Concepts. 1996;334(16):1039-44.
- VanCamp SP, Bloor CM, Mueller OF, Cantu RC, Olson HG. Nontraumatic sports death in high school and college athletes. Med Sci Sports Exerc. 27:641-647, 1995.
- Fuller C.M., McNulty C.M., Spring DA., et al. Preparticipation Screening of 5,615 High School Athletes for Risk of Sudden Cardiac Death, MSSE. 29:1131-1138, 1997.

Attachment 7

Suggested Screening Format for Marfan's Syndrome

Screen all men over 6 feet and all women over 5 feet 10 inches in height with echocardiogram and slit lamp examination when any two of the following are found:

1. Family History of Marfan's syndrome*
2. Cardiac murmur or mid-systolic click
3. Kyphoscoliosis
4. Anterior thoracic deformity
7. Arm span greater than height
6. Upper to lower body ration more than one standard deviation below the mean
7. Myopia
8. Ectopic lens

*This finding alone should prompt further investigation.

From Hara JH, Puffer JC. In Mellion MD: Sports Injuries & Athletic Problems. Philadelphia. Hanley & Belfus, Inc., 1988.

**FORM D – Health Practitioner, please refer to the letter & references provided on Form C.
 NIAA PRE-PARTICIPATION PHYSICAL EVALUATION
 (Physical to be completed during an athletes first and third year of participation)**

PHYSICAL EXAMINATION

DATE OF EXAMINATION: _____

NAME: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ % BODY FAT (optional): _____ PULSE: _____ BP: _____ (____/____/____)

VISION: R 20/ _____ L 20/ _____ CORRECTED: Y / N PUPILS: Equal _____ Unequal _____

<u>MEDICAL</u>	<u>NORMAL / ABSENT</u>	<u>ABNORMAL FINDINGS</u>	<u>EXPLAIN</u>	<u>INITIALS</u>
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Lungs				
Abdomen				
Genitalia (Males Only)				
Skin				
<u>CARDIOVASCULAR</u>				
Murmur that Increases From Supine to Standing				
Systolic Murmur Greater Than II/VI				
Any Diastolic Murmur				
Radial & Femoral Pulses				
<u>MUSCULOSKELETAL</u>				
Neck				
Back				
Shoulder / Arm				
Elbow / Forearm				
Wrist / Hand				
Hip / Thigh				
Knee				
Leg / Ankle				
Foot				
Stigmata of Marfan's Syndrome				

CLEARED after completing evaluation/rehabilitation for: _____

NOT CLEARED FOR: _____ REASON: _____

Recommendations: _____

Name of physician (print/type): _____ Phone: _____

Address: _____
 Street City State Zip Code

I, _____ hereby certify that I am a licensed _____, qualified to perform NIAA Pre-Participation Evaluations, and that on the date set forth below I performed all aspects of the NIAA Pre-Participation Evaluation on the above student. This student meets all physical examination requirements for participation in NIAA sanctioned sports.

Signature of Health Practitioner License Number Office Phone Number Date

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