

## Winfield School Afterschool Sports Permission Slip

Sport \_\_\_\_\_

Student Name \_\_\_\_\_

I hereby give my child permission to participate in the above sports program. In granting permission parents recognize the hazards of the sport and competition. The coach will take care of the students and will take appropriate precautions but assumes no responsibility for accidents. All students must have a completed physical form prior to participating in the sport and a completed sports related concussion and head injury form.

The program will include practice times outside of the school day to be determined by the coach and games with other school districts. Practice and home games will be held in the Winfield School gym and on the grounds as well as the Mutual Housing field. Away games will be held at other school facilities and grounds. All transportation will be provided by the Winfield School District to away games.

Students will be dismissed from practice and home games at the conclusion of the activity to walk home and away games upon returning to Winfield School. If your child is to be dismissed to a designated person, please note below.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ My child may be dismissed at the conclusion of practice and games (away games upon returning to Winfield School) to walk home.

\_\_\_\_\_ My child may not be dismissed to walk home at the conclusion of practice and games they will be picked up by: \_\_\_\_\_

## Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form

A concussion is a brain injury that can be caused by a blow to the head or body that disrupts normal functioning of the brain. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem solving, planning, memory, attention, concentration, and behavior.

The Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports. Second-impact syndrome occurs when a person sustains a second concussion while still experiencing symptoms of a previous concussion. It can lead to severe impairment and even death of the victim.

Legislation (P.L. 2010, Chapter 94) signed on December 7, 2010, mandated measures to be taken in order to ensure the safety of K-12 student-athletes involved in interscholastic sports in New Jersey. It is imperative that athletes, coaches, and parent/guardians are educated about the nature and treatment of sports related concussions and other head injuries. The legislation states that:

- All Coaches, Athletic Trainers, School Nurses, and School/Team Physicians shall complete an Interscholastic Head Injury Safety Training Program by the 2011-2012 school year.
- All school districts, charter, and non-public schools that participate in interscholastic sports will distribute annually this educational fact to all student athletes and obtain a signed acknowledgement from each parent/guardian and student-athlete.
- Each school district, charter, and non-public school shall develop a written policy describing the prevention and treatment of sports-related concussion and other head injuries sustained by interscholastic student-athletes.
- Any student-athlete who participates in an interscholastic sports program and is suspected of sustaining a concussion will be immediately removed from competition or practice. The student-athlete will not be allowed to return to competition or practice until he/she has written clearance from a physician trained in concussion treatment and has completed his/her district's graduated return-to-play protocol.

### Quick Facts

- Most concussions do not involve loss of consciousness
- You can sustain a concussion even if you do not hit your head
- A blow elsewhere on the body can transmit an "impulsive" force to the brain and cause a concussion

### Signs of Concussions (Observed by Coach, Athletic Trainer, Parent/Guardian)

- Appears dazed or stunned
- Forgets plays or demonstrates short term memory difficulties (e.g. unsure of game, opponent)
- Exhibits difficulties with balance, coordination, concentration, and attention
- Answers questions slowly or inaccurately
- Demonstrates behavior or personality changes
- Is unable to recall events prior to or after the hit or fall

### Symptoms of Concussion (Reported by Student-Athlete)

- |                                      |                                                                      |
|--------------------------------------|----------------------------------------------------------------------|
| • Headache                           | • Sensitivity to light/sound                                         |
| • Nausea/vomiting                    | • Feeling of sluggishness or foginess                                |
| • Balance problems or dizziness      | • Difficulty with concentration, short term memory, and/or confusion |
| • Double vision or changes in vision |                                                                      |

What Should a Student-Athlete do if they think they have a concussion?

- Don't hide it. Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- Report it. Don't return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return-to-play.
- Take time to recover. If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.

What can happen if a student-athlete continues to play with a concussion or returns to play too soon?

- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?

- To recover cognitive rest is just as important as physical rest. Reading, texting, testing-even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, be given extra time to complete assignments, as well as being offered other instructional strategies and classroom accommodations.

Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:

- Step 1: Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- Step 2: Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is increased heart rate.
- Step 3: Sport-specific exercise including skating, and/or running: no head impact activities. The objective of this step is to add movement.
- Step 4: Non contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- Step 5: Following medical clearance (consultation between school health care personnel and student-athlete's physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- Step 6: Return to play involving normal exertion or game activity.

For further information on Sports-Related Concussions and other Head Injuries, please visit:

[www.cdc.gov/concussion/sports/index.html](http://www.cdc.gov/concussion/sports/index.html)

[www.nfhs.com](http://www.nfhs.com)

[www.ncaa.org/health-safety](http://www.ncaa.org/health-safety)

[www.bianj.org](http://www.bianj.org)

[www.atstnj.org](http://www.atstnj.org)

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Signature of Student-Athlete

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Print Student-Athlete's Name

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Date

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Signature of Parent/Guardian

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Print Parent/Guardian's Name

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Date

# ■ PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

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Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines

☐ Pollens

☐ Food

☐ Stinging Insects

Explain “Yes” answers below. Circle questions you don’t know the answers to.

| GENERAL QUESTIONS                                                                                                                                                                                                                                                                                                                      | Yes | No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?                                                                                                                                                                                                                                                 |     |    |
| 2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections<br>Other: _____                                                                                                     |     |    |
| 3. Have you ever spent the night in the hospital?                                                                                                                                                                                                                                                                                      |     |    |
| 4. Have you ever had surgery?                                                                                                                                                                                                                                                                                                          |     |    |
| HEART HEALTH QUESTIONS ABOUT YOU                                                                                                                                                                                                                                                                                                       | Yes | No |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise?                                                                                                                                                                                                                                                             |     |    |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?                                                                                                                                                                                                                                           |     |    |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise?                                                                                                                                                                                                                                                          |     |    |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection<br><input type="checkbox"/> Kawasaki disease Other: _____ |     |    |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)                                                                                                                                                                                                                                             |     |    |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise?                                                                                                                                                                                                                                                 |     |    |
| 11. Have you ever had an unexplained seizure?                                                                                                                                                                                                                                                                                          |     |    |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise?                                                                                                                                                                                                                                           |     |    |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY                                                                                                                                                                                                                                                                                               | Yes | No |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?                                                                                                                           |     |    |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?                                                                                    |     |    |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?                                                                                                                                                                                                                                            |     |    |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?                                                                                                                                                                                                                                        |     |    |
| BONE AND JOINT QUESTIONS                                                                                                                                                                                                                                                                                                               | Yes | No |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?                                                                                                                                                                                                                   |     |    |
| 18. Have you ever had any broken or fractured bones or dislocated joints?                                                                                                                                                                                                                                                              |     |    |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?                                                                                                                                                                                                                 |     |    |
| 20. Have you ever had a stress fracture?                                                                                                                                                                                                                                                                                               |     |    |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)                                                                                                                                                                                       |     |    |
| 22. Do you regularly use a brace, orthotics, or other assistive device?                                                                                                                                                                                                                                                                |     |    |
| 23. Do you have a bone, muscle, or joint injury that bothers you?                                                                                                                                                                                                                                                                      |     |    |
| 24. Do any of your joints become painful, swollen, feel warm, or look red?                                                                                                                                                                                                                                                             |     |    |
| 25. Do you have any history of juvenile arthritis or connective tissue disease?                                                                                                                                                                                                                                                        |     |    |

| MEDICAL QUESTIONS                                                                                                   | Yes | No |
|---------------------------------------------------------------------------------------------------------------------|-----|----|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise?                                    |     |    |
| 27. Have you ever used an inhaler or taken asthma medicine?                                                         |     |    |
| 28. Is there anyone in your family who has asthma?                                                                  |     |    |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? |     |    |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area?                                          |     |    |
| 31. Have you had infectious mononucleosis (mono) within the last month?                                             |     |    |
| 32. Do you have any rashes, pressure sores, or other skin problems?                                                 |     |    |
| 33. Have you had a herpes or MRSA skin infection?                                                                   |     |    |
| 34. Have you ever had a head injury or concussion?                                                                  |     |    |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?      |     |    |
| 36. Do you have a history of seizure disorder?                                                                      |     |    |
| 37. Do you have headaches with exercise?                                                                            |     |    |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?              |     |    |
| 39. Have you ever been unable to move your arms or legs after being hit or falling?                                 |     |    |
| 40. Have you ever become ill while exercising in the heat?                                                          |     |    |
| 41. Do you get frequent muscle cramps when exercising?                                                              |     |    |
| 42. Do you or someone in your family have sickle cell trait or disease?                                             |     |    |
| 43. Have you had any problems with your eyes or vision?                                                             |     |    |
| 44. Have you had any eye injuries?                                                                                  |     |    |
| 45. Do you wear glasses or contact lenses?                                                                          |     |    |
| 46. Do you wear protective eyewear, such as goggles or a face shield?                                               |     |    |
| 47. Do you worry about your weight?                                                                                 |     |    |
| 48. Are you trying to or has anyone recommended that you gain or lose weight?                                       |     |    |
| 49. Are you on a special diet or do you avoid certain types of foods?                                               |     |    |
| 50. Have you ever had an eating disorder?                                                                           |     |    |
| 51. Do you have any concerns that you would like to discuss with a doctor?                                          |     |    |
| FEMALES ONLY                                                                                                        |     |    |
| 52. Have you ever had a menstrual period?                                                                           |     |    |
| 53. How old were you when you had your first menstrual period?                                                      |     |    |
| 54. How many periods have you had in the last 12 months?                                                            |     |    |

Explain “yes” answers here

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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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New Jersey Department of Education 2014; Pursuant to P.L.2013, c. 71

9-2681/0410

# ■ PREPARTICIPATION PHYSICAL EVALUATION

## THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

|                                                                                                            |            |           |
|------------------------------------------------------------------------------------------------------------|------------|-----------|
| 1. Type of disability                                                                                      |            |           |
| 2. Date of disability                                                                                      |            |           |
| 3. Classification (if available)                                                                           |            |           |
| 4. Cause of disability (birth, disease, accident/trauma, other)                                            |            |           |
| 5. List the sports you are interested in playing                                                           |            |           |
|                                                                                                            | <b>Yes</b> | <b>No</b> |
| 6. Do you regularly use a brace, assistive device, or prosthetic?                                          |            |           |
| 7. Do you use any special brace or assistive device for sports?                                            |            |           |
| 8. Do you have any rashes, pressure sores, or any other skin problems?                                     |            |           |
| 9. Do you have a hearing loss? Do you use a hearing aid?                                                   |            |           |
| 10. Do you have a visual impairment?                                                                       |            |           |
| 11. Do you use any special devices for bowel or bladder function?                                          |            |           |
| 12. Do you have burning or discomfort when urinating?                                                      |            |           |
| 13. Have you had autonomic dysreflexia?                                                                    |            |           |
| 14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? |            |           |
| 15. Do you have muscle spasticity?                                                                         |            |           |
| 16. Do you have frequent seizures that cannot be controlled by medication?                                 |            |           |

**Explain "yes" answers here**

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**Please indicate if you have ever had any of the following.**

|                                               | <b>Yes</b> | <b>No</b> |
|-----------------------------------------------|------------|-----------|
| Atlantoaxial instability                      |            |           |
| X-ray evaluation for atlantoaxial instability |            |           |
| Dislocated joints (more than one)             |            |           |
| Easy bleeding                                 |            |           |
| Enlarged spleen                               |            |           |
| Hepatitis                                     |            |           |
| Osteopenia or osteoporosis                    |            |           |
| Difficulty controlling bowel                  |            |           |
| Difficulty controlling bladder                |            |           |
| Numbness or tingling in arms or hands         |            |           |
| Numbness or tingling in legs or feet          |            |           |
| Weakness in arms or hands                     |            |           |
| Weakness in legs or feet                      |            |           |
| Recent change in coordination                 |            |           |
| Recent change in ability to walk              |            |           |
| Spina bifida                                  |            |           |
| Latex allergy                                 |            |           |

**Explain "yes" answers here**

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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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New Jersey Department of Education 2014; Pursuant to P.L.2013, c. 71



# PREPARTICIPATION PHYSICAL EVALUATION

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

### PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

| EXAMINATION                                                                                                                                                                                                               |              |                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------------------------------------------------------------------------------|
| Height _____                                                                                                                                                                                                              | Weight _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female                                  |
| BP _____ / _____ ( _____ / _____ )                                                                                                                                                                                        | Pulse _____  | Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL                                                                                                                                                                                                                   | NORMAL       | ABNORMAL FINDINGS                                                                              |
| Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul> |              |                                                                                                |
| Eyes/ears/nose/throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>                                                                                                                     |              |                                                                                                |
| Lymph nodes                                                                                                                                                                                                               |              |                                                                                                |
| Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PMI)</li> </ul>                                            |              |                                                                                                |
| Pulses <ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>                                                                                                                           |              |                                                                                                |
| Lungs                                                                                                                                                                                                                     |              |                                                                                                |
| Abdomen                                                                                                                                                                                                                   |              |                                                                                                |
| Genitourinary (males only) <sup>b</sup>                                                                                                                                                                                   |              |                                                                                                |
| Skin <ul style="list-style-type: none"> <li>HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>                                                                                                                    |              |                                                                                                |
| Neurologic <sup>c</sup>                                                                                                                                                                                                   |              |                                                                                                |
| MUSCULOSKELETAL                                                                                                                                                                                                           |              |                                                                                                |
| Neck                                                                                                                                                                                                                      |              |                                                                                                |
| Back                                                                                                                                                                                                                      |              |                                                                                                |
| Shoulder/arm                                                                                                                                                                                                              |              |                                                                                                |
| Elbow/forearm                                                                                                                                                                                                             |              |                                                                                                |
| Wrist/hand/fingers                                                                                                                                                                                                        |              |                                                                                                |
| Hip/thigh                                                                                                                                                                                                                 |              |                                                                                                |
| Knee                                                                                                                                                                                                                      |              |                                                                                                |
| Leg/ankle                                                                                                                                                                                                                 |              |                                                                                                |
| Foot/toes                                                                                                                                                                                                                 |              |                                                                                                |
| Functional <ul style="list-style-type: none"> <li>Duck-walk, single leg hop</li> </ul>                                                                                                                                    |              |                                                                                                |

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_
- ☐ Not cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician, APN, PA \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name \_\_\_\_\_ Sex ☐ M ☐ F Age \_\_\_\_\_ Date of birth \_\_\_\_\_

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_  
\_\_\_\_\_

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Other information \_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician, advanced practice nurse (APN), physician assistant (PA) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician, APN, PA \_\_\_\_\_

## Completed Cardiac Assessment Professional Development Module

Date \_\_\_\_\_ Signature \_\_\_\_\_

## Website Resources

- Sudden Death in Athletes  
<http://tinyurl.com/m2gjmvg>
- Hypertrophic Cardiomyopathy Association  
[www.4hcm.org](http://www.4hcm.org)
- American Heart Association [www.heart.org](http://www.heart.org)

## Collaborating Agencies:

### American Academy of Pediatrics New Jersey Chapter

3836 Quakerbridge Road, Suite 108  
Hamilton, NJ 08619  
(p) 609-842-0014  
(f) 609-842-0015  
[www.aapnj.org](http://www.aapnj.org)



### American Heart Association

1 Union Street, Suite 301  
Robbinsville, NJ, 08691  
(p) 609-208-0020  
[www.heart.org](http://www.heart.org)



### New Jersey Department of Education

PO Box 500  
Trenton, NJ 08625-0500  
(p) 609-292-5935  
[www.state.nj.us/education/](http://www.state.nj.us/education/)



### New Jersey Department of Health

P. O. Box 360  
Trenton, NJ 08625-0360  
(p) 609-292-7837  
[www.state.nj.us/health](http://www.state.nj.us/health)



**Lead Author:** American Academy of Pediatrics,  
New Jersey Chapter

**Written by:** Initial draft by Sushma Raman Hebbar,  
MD & Stephen G. Rice, MD PhD

**Additional Reviewers:** NJ Department of Education,  
NJ Department of Health and Senior Services,  
American Heart Association/New Jersey Chapter,  
NJ Academy of Family Practice, Pediatric Cardiologists,  
New Jersey State School Nurses

**Revised 2014:** Nancy Curry, EdM;  
Christene DeWitt-Parker, MSN, CSN, RN;  
Lakota Kruse, MD, MPH; Susan Martz, EdM;  
Stephen G. Rice, MD; Jeffrey Rosenberg, MD,  
Louis Teichholz, MD; Perry Weinstock, MD

# SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

## The Basic Facts on Sudden Cardiac Death in Young Athletes



STATE OF NEW JERSEY  
DEPARTMENT OF EDUCATION

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



American Heart  
Association   
*Learn and Live*



## SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

**S**udden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?



### What is sudden cardiac death in the young athlete?

Sudden cardiac death is the result of an unexpected failure of proper heart function, usually (about 60% of the time) during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

### How common is sudden death in young athletes?

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common: in males than in females; in football and basketball than in other sports; and in African-Americans than in other races and ethnic groups.



### What are the most common causes?

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping blood to the brain and body. This is called ventricular fibrillation (ven-TRICK-you-lar fib-roo-LAY-shun). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is hypertrophic cardiomyopathy (hi-per-TRO-fic CAR-dee-oh-my-OP-a-thee) also called HCM. HCM is a disease of the heart, with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is congenital (con-JEN-it-al) (i.e., present from birth) abnormalities of the coronary arteries. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called "coronary artery disease," which may lead to a heart attack).



## SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

Other diseases of the heart that can lead to sudden death in young people include:

- Myocarditis (my-oh-car-DIE-tis), an acute inflammation of the heart muscle (usually due to a virus).
- Dilated cardiomyopathy, an enlargement of the heart for unknown reasons.
- Long QT syndrome and other electrical abnormalities of the heart which cause abnormal fast heart rhythms that can also run in families.
- Marfan syndrome, an inherited disorder that affects heart valves, walls of major arteries, eyes and the skeleton. It is generally seen in unusually tall athletes, especially if being tall is not common in other family members.

### Are there warning signs to watch for?

In more than a third of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. Warning signs are:

- Fainting, a seizure or convulsions during physical activity;
- Fainting or a seizure from emotional excitement, emotional distress or being startled;
- Dizziness or lightheadedness, especially during exertion;
- Chest pains, at rest or during exertion;
- Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation;
- Fatigue or tiring more quickly than peers; or
- Being unable to keep up with friends due to shortness of breath (labored breathing).

### What are the current recommendations for screening young athletes?

New Jersey requires all school athletes to be examined by their primary care physician ("medical home") or school physician at least once per year. The New Jersey Department of Education requires use of the specific Preparticipation Physical Examination Form (PPE).

This process begins with the parents and student-athletes answering questions about symptoms during exercise (such as chest pain, dizziness, fainting, palpitations or shortness of breath); and questions about family health history.

The primary healthcare provider needs to know if any family member died suddenly during physical activity or during a seizure. They also need to know if anyone in the family under the age of 50 had an unexplained sudden death such as drowning or car accidents. This information must be provided annually for each exam because it is so essential to identify those at risk for sudden cardiac death.

The required physical exam includes measurement of blood pressure and a careful listening examination of the heart, especially for murmurs and rhythm abnormalities. If there are no warning signs reported on the health history and no abnormalities discovered on exam, no further evaluation or testing is recommended.

### Are there options privately available to screen for cardiac conditions?

Technology-based screening programs including a 12-lead electrocardiogram (ECG) and echocardiogram (ECHO) are noninvasive and painless options parents may consider in addition to the required

PPE. However, these procedures may be expensive and are not currently advised by the American Academy of Pediatrics and the American College of Cardiology unless the PPE reveals an indication for these tests. In addition to the expense, other limitations of technology-based tests include the possibility of "false positives" which leads to unnecessary stress for the student and parent or guardian as well as unnecessary restriction from athletic participation.

The United States Department of Health and Human Services offers risk assessment options under the Surgeon General's Family History Initiative available at <http://www.hhs.gov/familyhistory/index.html>.

### When should a student athlete see a heart specialist?

If the primary healthcare provider or school physician has concerns, a referral to a child heart specialist, a pediatric cardiologist, is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound test to allow for direct visualization of the heart structure, will likely also be done. The specialist may also order a treadmill exercise test and a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.

### Can sudden cardiac death be prevented just through proper screening?

A proper evaluation should find most, but not all, conditions that would cause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a

normal screening evaluation, such as an infection of the heart muscle from a virus.

This is why screening evaluations and a review of the family health history need to be performed on a yearly basis by the athlete's primary healthcare provider. With proper screening and evaluation, most cases can be identified and prevented.

### Why have an AED on site during sporting events?

The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restore the heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).

N.J.S.A. 18A:40-41a through c, known as "Janet's Law," requires that at any school-sponsored athletic event or team practice in New Jersey public and nonpublic schools including any of grades K through 12, the following must be available:

- An AED in an unlocked location on school property within a reasonable proximity to the athletic field or gymnasium; and
- A team coach, licensed athletic trainer, or other designated staff member if there is no coach or licensed athletic trainer present, certified in cardiopulmonary resuscitation (CPR) and the use of the AED; or
- A State-certified emergency services provider or other certified first responder.

The American Academy of Pediatrics recommends the AED should be placed in central location that is accessible and ideally no more than a 1 to 1½ minute walk from any location and that a call is made to activate 911 emergency system while the AED is being retrieved.

**Sudden Cardiac Death Pamphlet**  
**Sign-Off Sheet**

Name of School District: \_\_\_\_\_

Name of Local School: \_\_\_\_\_

I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature: \_\_\_\_\_

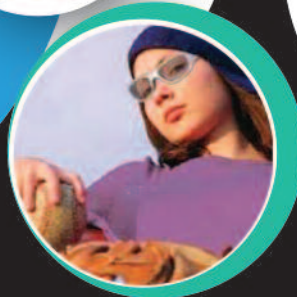
Parent or Guardian  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# SPORTS-RELATED EYE INJURIES:

## AN EDUCATIONAL FACT SHEET FOR PARENTS



Participating in sports and recreational activities is an important part of a healthy, physically active lifestyle for children. Unfortunately, injuries can, and do, occur. Children are at particular risk for sustaining a sports-related eye injury and most of these injuries can be prevented. Every year, more than 30,000 children sustain serious sports-related eye injuries. Every 13 minutes, an emergency room in the United States treats a sports-related eye injury.<sup>1</sup> According to the National Eye Institute, the sports with the highest rate of eye injuries are: baseball/softball, ice hockey, racquet sports, and basketball, followed by fencing, lacrosse, paintball and boxing.

Thankfully, there are steps that parents can take to ensure their children's safety on the field, the court, or wherever they play or participate in sports and recreational activities.

### Prevention of Sports-Related Eye Injuries

Approximately 90% of sports-related eye injuries can be prevented with simple precautions, such as using protective eyewear.<sup>2</sup> **Each sport has a certain type of recommended protective eyewear, as determined by the American Society for Testing and Materials (ASTM). Protective eyewear should sit comfortably on the face. Poorly fitted equipment may be uncomfortable, and may not offer the best eye protection. Protective eyewear for sports includes, among other things, safety goggles and eye guards, and it should be made of polycarbonate lenses, a strong, shatterproof plastic. Polycarbonate lenses are much stronger than regular lenses.**<sup>3</sup>

Health care providers (HCP), including family physicians, ophthalmologists, optometrists, and others, play a critical role in advising students, parents and guardians about the proper use of protective eyewear. To find out what kind of eye protection is recommended, and permitted for your child's sport, visit the National Eye Institute at <http://www.nei.nih.gov/sports/findingprotection.asp>. Prevent Blindness America also offers tips for choosing and buying protective eyewear at <http://www.preventblindness.org/tips-buying-sports-eye-protectors>, and <http://www.preventblindness.org/recommended-sports-eye-protectors>.

It is recommended that all children participating in school sports or recreational sports wear protective eyewear. Parents and coaches need to make sure young athletes protect their eyes, and properly gear up for the game. Protective eyewear should be part of any uniform to help reduce the occurrence of sports-related eye injuries. Since many youth teams do not require eye protection, parents may need to ensure that their children wear safety glasses or goggles whenever they play sports. Parents can set a good example by wearing protective eyewear when they play sports.

<sup>1</sup> National Eye Institute, National Eye Health Education Program, Sports-Related Eye Injuries: What You Need to Know and Tips for Prevention, [www.nei.nih.gov/sports/pdf/sportsrelatedeyeinjuries.pdf](http://www.nei.nih.gov/sports/pdf/sportsrelatedeyeinjuries.pdf), December 26, 2013.

<sup>2</sup> Rodriguez, Jorge O., D.O., and Lavina, Adrian M., M.D., Prevention and Treatment of Common Eye Injuries in Sports, <http://www.aafp.org/afp/2003/0401/p1481.html>, September 4, 2014; National Eye Health Education Program, Sports-Related Eye Injuries: What You Need to Know and Tips for Prevention, [www.nei.nih.gov/sports/pdf/sportsrelatedeyeinjuries.pdf](http://www.nei.nih.gov/sports/pdf/sportsrelatedeyeinjuries.pdf), December 26, 2013.

<sup>3</sup> Bedinghaus, Troy, O.D., Sports Eye Injuries, [http://vision.about.com/od/emergencyeyecare/a/Sports\\_Injuries.htm](http://vision.about.com/od/emergencyeyecare/a/Sports_Injuries.htm), December 27, 2013.

## Most Common Types of Eye Injuries



The most common types of eye injuries that can result from sports injuries are blunt injuries, corneal abrasions and penetrating injuries.

♦ **Blunt injuries:** Blunt injuries occur when the eye is suddenly compressed by impact from an object. Blunt injuries, often caused by tennis balls, racquets, fists or elbows, sometimes cause a black eye or hyphema (bleeding in front of the eye). More serious blunt injuries often break bones near the eye, and may sometimes seriously damage important eye structures and/or lead to vision loss.

♦ **Corneal abrasions:** Corneal abrasions are painful scrapes on the outside of the eye, or the cornea. Most corneal abrasions eventually heal on their

own, but a doctor can best assess the extent of the abrasion, and may prescribe medication to help control the pain. The most common cause of a sports-related corneal abrasion is being poked in the eye by a finger.

♦ **Penetrating injuries:** Penetrating injuries are caused by a foreign object piercing the eye. Penetrating injuries are very serious, and often result in severe damage to the eye. These injuries often occur when eyeglasses break while they are being worn. Penetrating injuries must be treated quickly in order to preserve vision.<sup>4</sup>

- Pain when looking up and/or down, or difficulty seeing;
- Tenderness;
- Sunken eye;
- Double vision;
- Severe eyelid and facial swelling;
- Difficulty tracking;

## Signs or Symptoms of an Eye Injury



- The eye has an unusual pupil size or shape;
- Blood in the clear part of the eye;
- Numbness of the upper cheek and gum; and/or
- Severe redness around the white part of the eye.

## What to do if a Sports-Related Eye Injury Occurs



If a child sustains an eye injury, it is recommended that he/she receive immediate treatment from a licensed HCP (e.g., eye doctor) to reduce the risk of serious damage, including blindness. It is also recommended that the child, along with his/her parent or guardian, seek guidance from the HCP regarding the appropriate amount of time to wait before returning to sports competition or practice after sustaining an eye injury. The school nurse and the child's teachers should also be notified when a child sustains an eye injury. A parent or guardian should also provide the school nurse with a physician's note detailing the nature of the eye injury, any diagnosis, medical orders for

the return to school, as well as any prescription(s) and/or treatment(s) necessary to promote healing, and the safe resumption of normal activities, including sports and recreational activities.

## Return to Play and Sports

According to the American Family Physician Journal, there are several guidelines that should be followed when students return to play after sustaining an eye injury. For



example, students who have sustained significant ocular injury should receive a full examination and clearance by an ophthalmologist or optometrist. In addition, students should not return to play until the period of time recommended by their HCP has elapsed. For more

minor eye injuries, the athletic trainer may determine that

it is safe for a student to resume play based on the nature of the injury, and how the student feels. No matter what degree of eye injury is sustained, it is recommended that students wear protective eyewear when returning to play and immediately report any concerns with their vision to their coach and/or the athletic trainer.

**Additional information on eye safety can be found at <http://isee.nei.nih.gov> and <http://www.nei.nih.gov/sports>.**

<sup>4</sup>Bedinghaus, Troy, O.D., Sports Eye Injuries, [http://vision.about.com/od/emergencyeyecare/a/Sports\\_Injuries.htm](http://vision.about.com/od/emergencyeyecare/a/Sports_Injuries.htm), December 27, 2013.