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 _____ Measles _____

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**

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

** Revised 5-2010; June 2012

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 cardiomyopathey, 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 _____

MEDICAL	**NORMAL /ABSENT**	**ABNORMAL FINDINGS**	**EXPLAIN**	**INITIALS**
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Lungs				
Abdomen				
Genitalia (Males Only)				
Skin				
CARDIOVASCULAR				
Murmur that Increases From Supine to Standing				
Systolic Murmur Greater Than II/VI				
Any Diastolic Murmur				
Radial & Femoral Pulses				
MUSCULOSKELETAL				
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**

Revised 5-2010; June 2012

FORM E -- NIAA HEALTH QUESTIONNAIRE / INTERIM FORM

This evaluation should be completed only if you have a physical on file from last year.

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. A positive response to any of the following questions requires a medical examination before activity can resume.

NAME: _____ AGE: _____ GRADE: _____ DATE: _____

ADDRESS: _____ PHONE: _____

SPORT(S): _____

DATE OF LAST COMPLETE SPORTS PHYSICAL (PPE): _____ WHERE: _____

SINCE YOUR LAST COMPLETE PREPARTICIPATION EXAM (PPE):

		YES	***NO***
1.	Have you had a medical illness or injury that required you to visit a physician and miss FIVE or more consecutive days of school or sports?	_____	_____
2.	Have you been hospitalized overnight	_____	_____
3.	a. Have you passed out or been dizzy with 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. Has someone in your family died, or developed serious problems, due to heart disease who was younger than 50 years old?	_____	_____
	e. Have you learned of anyone in your family who has any history of hypertropic cardiomyopathy, dilated cardiomyopathy long QT syndrome or Marfan's syndrome?	_____	_____
4.	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. Have you developed frequent or severe headaches?	_____	_____
	e. Have you developed numbness or tingling in your arms, hands, legs, or feet?	_____	_____
5.	Have you become sick from exercising in the heat?	_____	_____
6.	Have you developed a cough, wheeze, or have trouble breathing during or after activity?	_____	_____
7.	Have you started requiring 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)?	_____	_____

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		YES	*NO*
8.	Have you had any problems with your eyes or vision, other than requiring glasses or contacts?	_____	_____
9.	Have you had any problems with sprains, dislocations, fractures, pain or swelling in the following muscles, tendons, bones, or joints that currently bother you?	_____	_____

If yes, check appropriate item below.

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

10.	Would you like to talk to a physician about your weight, about stress, anger, depression or any other issues?	_____	_____

FEMALES ONLY

11.	If you have been having periods for one year or longer, have they become less regular?	_____	_____

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE SEE YOUR FAMILY PHYSICIAN FOR A COMPLETE PHYSICAL.

12. Have you developed any new allergies (for example, to pollen, medicine, food, or stinging insects)? If so, please list:

_____

_____

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

Approved: February 2000: REVISED May 2001; June, 2002; June 2012

NIAA CONCUSSION PREVENTION, TREATMENT AND MANAGEMENT POLICY

Participation in NIAA sanctioned sports is a privilege and responsibility which requires all participants to adhere to athletic training rules imposed by the Nevada Interscholastic Activities Association ("NIAA"), as well as the school district and member, affiliate or provisional school the student attends and represents. Adherence to training rules ensures that all student athletes are in top physical condition, minimizes potential for significant injury, and further ensures that all member and affiliate school athletic teams are protected and properly represented by their student athletes.

A concussion is a brain injury that results from a bump, blow or jolt to the head or body which causes the brain to move rapidly in the skull and which disrupts normal brain function. The Centers for Disease Control and Prevention of the United States Department of Health and Human Services estimates that as many as 3.8 million concussions occur each year in the United States which are related to participation in sports and other recreational activities. Student athletes who continue to participate in an athletic activity while suffering from a concussion or suffering from the symptoms of an injury to the head are at a greater risk for catastrophic injury to the brain or even death. Ensuring that a student athlete who sustains or is suspected of sustaining a concussion or other injury to the head receives the appropriate medical care before returning to an athletic activity will significantly reduce the child's risk of sustaining greater injury in the future.

The Nevada Legislature passed AB455, now codified at NRS 386.435, during the 2011 Legislative session which mandates the NIAA develop a policy addressing concussion prevention, treatment and management which applies to all sports and activities sanctioned by the NIAA.

THEREFORE, the NIAA hereby adopts the following policy for purposes of prevention, treatment and management of injuries to the head which may occur during a pupil's participation in interscholastic activities and events, including, without limitation, a concussion of the brain. This policy constitutes the minimum standard that all member schools shall follow. School Districts and member schools may choose to adopt and follow more stringent programs and guidelines pertaining to the prevention, treatment and management of concussions and those programs shall take precedence over this policy.

1. Each school year before a student athlete is allowed to participate in an Interscholastic activity or event, the student athlete and his or her parent or legal guardian must be provided with a copy of this policy. Participation in interscholastic activities or events shall be construed in accordance with the definition of "participation" as set forth in NAC 386.615 and 386.695.

2. The student athlete and his or her parent or legal guardian must sign the statement attached to this policy acknowledging that they have read and understand the terms and conditions of the policy, and agree to be bound by the policy.

3. If a student athlete sustains, or is suspected of sustaining, an injury to the head while participating in any NIAA activity or event the pupil must:

   (a) Be immediately removed from the activity or event; and

   (b) May only return to the activity or event if the parent or legal guardian of the student athlete first provides the athletic administrator of the member school a signed statement from a provider of health care indicating that the student athlete is medically cleared for participation in the activity or event. The statement must include the date on which the pupil may return to the activity or event.

   (c) "Provider of health care," as used in (b), above, means a physician licensed under Chapter 630 or 633 of the Nevada Revised Statutes ("NRS"), a physical therapist licensed under Chapter 640 of NRS or an athletic trainer licensed under Chapter 640B of NRS.

NIAA CONCUSSION PREVENTION, MANAGEMENT AND TREATMENT POLICY STUDENT AND PARENTAL ACKNOWLEDGMENT

We, the undersigned, acknowledge that we have been provided with a copy of the NIAA Concussion Prevention, Management and Treatment Policy, and that we have read and understand the policy in its entirety, or it has been read to us and we understand the same. We hereby acknowledge and agree to follow all procedures set forth in the NIAA Concussion Prevention, Management and Treatment Policy at a11 times during which our son or daughter participates in NIAA sanctioned activities and events.

We further acknowledge that if the member school our son or daughter participates for has adopted a more stringent program for the prevention, treatment and management of concussions, including by way of example only, the Second Impact Program, that we will be required to comply with the terms and conditions of that program before our son or daughter may return to a sanctioned activity or event.

Dated: _____ _____
Student

Dated: _____ _____
Parent/Legal Guardian

Parent/Legal Guardian