St. Augustine of Canterbury School

A National Blue Ribbon School

Member of NCEA & AdvancED Accredited

45 Henderson Road • Kendall Park, New Jersey 08824

(732) 297-6042 • Fax (732) 297-7062

Medical Forms

Grades 3-8

If your child will be participating in any sport activity

you will need to complete the

FORMS REQUIRED FOR SPORTS AND CHEERLEADING

STAFFED BY THE
RELIGIOUS SISTERS FILIPPINI

St. Augustine of Canterbury Health History Form

Please Have Physician Fill Out and Sign; Form Must Be On file By the First Day of School

Student Name:_____ **M__F__Date of Birth**_____

Please Circle No or Yes and Provide Any Explanation of Medical Conditions:

Hospitalization/Surgery	**No**	**Yes**_____
Asthma:	**No**	**Yes**_____
Food Allergies:	**No**	**Yes**_____
Insect/ Bee Allergies	**No**	**Yes**_____
Seasonal Allergies:	**No**	**Yes**_____
Heart Condition:	**No**	**Yes**_____
Vision Problems:	**No**	**Yes**_____
Wears Glasses/Contacs:	**No**	**Yes**_____
Hearing Disorder:	**No**	**Yes**_____
Diabetes:	**No**	**Yes**_____
Seizure Disorder:	**No**	**Yes**_____
Bleeding Disorder:	**No**	**Yes**_____
Muscular Problem:	**No**	**Yes**_____
Orthopedic Problem:	**No**	**Yes**_____
Headaches/Nose Bleeds	**No**	**Yes**_____
Stomach/GI Problem	**No**	**Yes**_____
Other Conditions	**No**	**Yes**_____

List Medications or Special Dietary Needs_____

Student May Participate Fully in all Physical Activities with No Restrictions: Yes No
Explanation of limitations if indicated:_____

_____

Physician Signature_____ **Date**_____

ST. AUGUSTINE OF CANTERBURY SCHOOL
45 HENDERSON ROAD
KENDALL PARK, NJ 08824
PHONE (732) 297-6042 FAX (732) 297-7062

MEDICAL EXAMINATION OF STUDENT BY PRIVATE PHYSICIAN
(Please Print)

Student's Name: _____ Date of Exam: _____

Physician Name: _____ Phone #: _____

Immunization(s) and/or test(s) given on this date: _____

_____

Significant Factors in Home Situation: _____

_____

Please indicate below by check, any positive findings and describe fully in the section on the right.

Exam		Description	Treatment Advised
Skin			
Eyes			
Ears			
Nose & Throat			
Mouth			
Glands			
Heart			
Lungs			
Abdomen			
Hernia			
Orthopedic			
Genito-Urinary			
Nutrition			
Other			

Vision (if done) R: _____ L: _____
Hearing (if done): R: _____ L: _____
Blood Pressure: _____

Height: _____
Weight: _____
Scoliosis: Negative: _____
Positive: _____

Student may have age/weight appropriate dosage of Tylenol for occasional headache without fever.
Parents are informed of time administered. Yes ___ No ___

Specify medical recommendations to School for academic and activity programs (use additional paper if necessary).

Examining Physician: _____ License #: _____
Address: _____ Phone #: _____

Please attach a copy of Immunization Record

St. Augustine of Canterbury School
45 Henderson Road
Kendall Park, NJ 08824
Phone: 732-297-6042 Fax: 732-297-7062

Authorization to Administer Medication In School
(To Be Kept Confidential Upon Completion)

Student Name: _____ Grade: _____

Diagnosis/Illness: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Special Directions: _____

Possible Side Effects: _____

****

I certify that the above information regarding this student is correct, and that administration of the medication to this student is necessary.

Signature of Prescribing Physician: _____ Date: _____

Address: _____ Phone #: _____

I/We authorize the School Nurse or, in his/her absence, another school employee designated and trained by the School Nurse to administer the above medication(s) as indicated. I/We understand and agree that the School, the School Nurse and its employees shall not be liable for any injury to the Student resulting from the administration of the medication(s) as authorized by my signature below.

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

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

St. Augustine of Canterbury School
45 Henderson Road
Kendall Park, NJ 08824
Phone: 732-297-6042 Fax: 732-297-7062

Authorization Form for Over-the-Counter Medications

Student Name: _____

Over –the-counter medications must have a physician's approval and parent/guardian permission to be administered. Below is a list of common over-the-counter medications that may be needed occasionally throughout the day. Please have your ***physician*** fill out and sign the form if you would like these medications available for your child:

Tylenol or Acetaminophen (include dosage) _____

Motrin or Ibuprofen (include dosage) _____

Benadryl or Antihistamine (include dosage) _____

Tums (include dosage) _____

Cough Drops/Throat Soothers (include dosage) _____

Calamine Lotion (include dosage) _____

Saline or Other Eye Rinse (include dosage) _____

Physician's Signature: _____ Date: _____

I/We authorize the School Nurse or, in his/her absence, another school employee designated and trained by the School Nurse to administer the above medication(s) as indicated. I/We understand and agree that the School, the School Nurse and its employees shall not be liable for any injury to the Student resulting from the administration of the medication(s) as authorized by my signature below.

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

FORMS REQUIRED FOR SPORTS AND CHEERLEADING
Grades 3-8

Dear Parents:

The required forms for students participating in intramural sports in the State of New Jersey must be on file in the school nurse's office before the first day of practice or your child may not participate until all forms have been received. All forms must be filled out in completion or they will be returned. Thank you for your attention to these important requirements.

SPORTS PHYSICAL-EXAM

The **NJ Pre-Participation Physical Evaluation Form** is the only acceptable form allowed for students participating in sports or cheerleading. No other forms or statements from physicians will be accepted. The forms must be filled in completely by the physician including vision, hearing, etc. or the form will be returned for completion.

The Health History Form is part of the Pre-Participation Physical Evaluation Form and is completed by the parent or guardian. If there are any unanswered questions, the form will be returned for completion.

SUDDEN CARDIAC DEATH IN ATHLETES PAMPHLET & SIGN-OFF SHEET

The pamphlet must be reviewed by students and parents. The sign off sheet must be signed by the student and parent and submitted with the Pre-Participation Physical Evaluation form.

SPORTS RELATED CONCUSSION FACT SHEET AND ACKNOWLEDGEMENT FORM

These forms should be reviewed by the student and parent and should be returned with signatures that they have been reviewed.

ATTENTION PARENT/GUARDIAN: The preparticiaption physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

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

_____

_____

_____

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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 _____

HE0503 9-2681/0410

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

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		
	Yes	**No**
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

_____

_____

_____

_____

_____

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

	Yes	**No**
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

_____

_____

_____

_____

_____

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 _____

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

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. **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?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP ____/____ (____/____) Pulse _____	Vision R 20/_____ L 20/_____	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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 _____

HE0503 9-2681 0410

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

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 _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

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 _____

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

State of New Jersey
DEPARTMENT OF EDUCATION

HEALTH HISTORY UPDATE QUESTIONNAIRE

Name of School _____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student _____ **Age**_____ **Grade** _____

Date of Last Physical Examination_____ **Sport**_____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes____ No____
   If yes, describe in detail _____
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes____ No____
   If yes, explain in detail _____
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes____ No____
   If yes, describe in detail _____
4. Fainted or "blacked out?" Yes____ No____
   If yes, was this during or immediately after exercise? _____
5. Experienced chest pains, shortness of breath or "racing heart?" Yes____ No____
   If yes, explain _____
6. Has there been a recent history of fatigue and unusual tiredness? Yes____ No____
7. Been hospitalized or had to go to the emergency room? Yes____ No____
   If yes, explain in detail _____
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes____
9. Started or stopped taking any over-the-counter or prescribed medications? Yes____ No____
   If yes, name of medication(s) _____

Date:_____ **Signature of parent/guardian** _____

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE'S OFFICE

E14-00284

St. Augustine of Canterbury School
45 Henderson Road
Kendall Park, NJ 08824
Phone: 732-297-6042 Fax: 732-297-7062

Authorization Form for Over-the-Counter Medications

Student Name: _____

Over –the-counter medications must have a physician's approval and parent/guardian permission to be administered. Below is a list of common over-the-counter medications that may be needed occasionally throughout the day. Please have your ***physician*** fill out and sign the form if you would like these medications available for your child:

Tylenol or Acetaminophen (include dosage) _____

Motrin or Ibuprofen (include dosage) _____

Benadryl or Antihistamine (include dosage) _____

Tums (include dosage) _____

Cough Drops/Throat Soothers (include dosage) _____

Calamine Lotion (include dosage) _____

Saline or Other Eye Rinse (include dosage) _____

Physician's Signature: _____ Date: _____

I/We authorize the School Nurse or, in his/her absence, another school employee designated and trained by the School Nurse to administer the above medication(s) as indicated. I/We understand and agree that the School, the School Nurse and its employees shall not be liable for any injury to the Student resulting from the administration of the medication(s) as authorized by my signature below.

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

Website Resources

- Sudden Death in Athletes
  www.cardiachealth.org/sudden-death-in-athletes
- Hypertrophic Cardiomyopathy Association
  www.4hcm.org
- American Heart Association 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

American Heart Association
1 Union Street, Suite 301
Robbinsville, NJ, 08691
(p) 609-208-0020
www.heart.org

New Jersey Department of Education
PO Box 500
Trenton, NJ 08625-0500
(p) 609-292-5935
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

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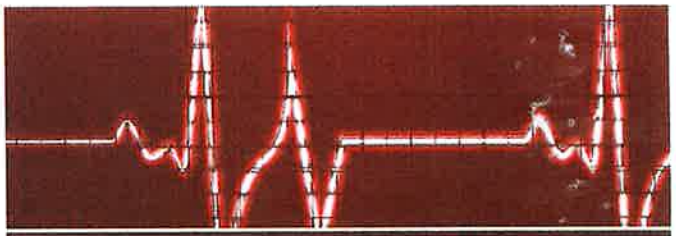
SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

The Basic Facts on Sudden Cardiac Death in Young Athletes

STATE OF NEW JERSEY
DEPARTMENT OF EDUCATION

American Heart Association
Learn and Live



Sudden 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.

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.

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 Annual Athletic Pre-Participation Physical Examination Form.

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.

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.

State of New Jersey
DEPARTMENT OF EDUCATION

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

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 to 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 www.nfhs.com
www.ncaa.org/health-safety www.bianj.org www.atsnj.org

Signature of Student-Athlete	Print Student-Athlete's Name	Date
Signature of Parent/Guardian	Print Parent/Guardian's Name	Date