NIAA 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 hypertrophic 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?	____	____
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?	____	____

	YES	NO
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(s) below.

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

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:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

_____ _____ _____ _____
Signature of Athlete Date Signature of Parent/Legal Guardian Date

Note: Physicians must sign Form B and Form D

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

_____
Approved: February 2000; June 2012

Dear Health Practitioner; **(NIAA FORM C)**

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

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

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

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

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

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

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

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

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

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

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

Published by the NIAA Sports Medicine Advisory Committee.
Approved: February 2000; June 2012

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 ratio 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.

NIAA FORM D -- Health Practitioner, please refer to the letter & references provided on Form C.
NIAA PRE-PARTICIPATION PHYSICAL EVALUATION

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