

FORMS ARE DUE NO LATER THAN AUGUST 19, 2019

Craig Lower/Middle School Health Forms 2019-2020 Checklist

The following forms should be filled out each year by EVERY student.

- Preparticipation Physical Evaluation, History Form
- Physical Examination Form
- The Athlete with Special Needs supplemental History Form
- Clearance Form
- State of NJ, Health History update Questionnaire
- Authorization to administer medication by the school nurse
- Permission to share medical information
- The Craig School emergency information
- NJSIAA Parent/Guardian concussion policy form
- Sudden Cardiac Death Pamphlet sign off sheet

***Please include a copy of current immunization records**

Important information for rising 6th graders: One of the NJ immunization requirements for pupils in schools mandates that upon entering 6th grade the student have documentation of receiving the Meningitis vaccine and a Tetanus booster. Please see that your child's medical records are in compliance with this regulation when submitting documents at the start of the school year.

Any questions please email or call our school nurse Ellen at emeisenbacher@craigschool.org or call 973 334 4375 x107

Please make copies for your records and mail to:

Sharon Anderle
The Craig School
15 Tower Hill Road
Mountain Lakes, NJ 07046

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The Craig School

15 Tower Hill Road

Mountain Lakes, NJ 07046

ATTENTION PARENT/GUARDIAN: The preparticipation 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	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
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 Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MMSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have stroke, callus, or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required X-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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 dysplasia)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotic, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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 _____

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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		
6. Do you regularly use a brace, assistive device, or prosthetic?	Yes	No
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 _____

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

NOTE: The preparticipation physical examination must be conducted by a health care provider who: 1) is a licensed physician, advanced practice 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

- 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 6-14).

**MUST INCLUDE COPY OF
IMMUNIZATION RECORD**

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 • Marfan stigmata (scoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) [†]		
Skin • HSV, lesions suggestive of MRSA, linea corporis		
Neurologic [‡]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/leg		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[†]Consider only exam if in private setting. Having third party present is recommended.
[‡]Consider cognitive evaluation or baseline neuropsychologic 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 this 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 of exam _____
 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 _____

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 Cardio Assessment Professional Development Module

Date _____ Signature _____

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 practices 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 _____ No _____

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



THE CRAIG SCHOOL

AUTHORIZATION TO ADMINISTER MEDICATIONS BY THE SCHOOL NURSE

New Jersey law requires a physician's written order and parent/guardian authorization for administration of any medication, prescription or over the counter. In order to administer any prescription medication to your child, The Craig School must have:

- a. Written authorization from the prescribing physician indicating the medication dosage and time of administration.
- b. Written authorization from the parent to administer medication

All medications must come to school in a clearly marked pharmacy container with the prescription label for your child. Unlabeled or incorrectly labeled containers and/or loose pills will be returned to the parent.

Any change in prescription during the school year or during the summer program must be accompanied by signed authorization from both parent and physician.

NAME OF STUDENT: _____

GRADE: _____ DATE OF BIRTH: _____

The following prescription/non-prescription medication(s) may be administered for the current school year (non-prescription may include e.g. Tylenol, Advil, Lozenges, Benadryl, Pepto-Bismol)

Medications:

Dosage(s): _____

Time(s): _____

Reason for Medication: _____

Medications:

Dosage(s): _____

Time(s): _____

Reason for Medication: _____

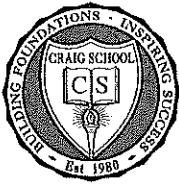
I do not give permission for this student to receive over the counter medication

Physician Signature	Physician Name (Please Print)	Date
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AUTHORIZATION OF PARENT/GUARDIAN FOR THE SCHOOL NURSE TO ADMINISTER THE ABOVE MEDICATION(S)

I hereby authorize that the school nurse give my child the medication ordered by his/her physician.

Parent/Guardian Signature	Parent/Guardian Name (Please Print)	Date
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THE CRAIG SCHOOL

PERMISSION TO SHARE MEDICAL INFORMATION

Everyday each student is in contact with a variety of teachers and other staff members. In order to be sure that your child's needs are being met it is sometimes important to share medical information about him or her with these staff members. This sharing also helps us to collaborate effectively with the health care professionals who are working with your child. The kinds of information shared may include: known allergies, special diet or food restrictions, a history of seizures, and medications that are taken routinely. It is especially important that faculty members are aware when there has been a change in medication so that they can share with you and your child's physician any observed changes in behavior.

We are asking your permission to share these kinds of information as we deem necessary. Information may be shared either orally or in writing with those who will be working with your child. Any information that you do not wish to be shared will, of course, be kept confidential.

Child's Name _____

_____ I give permission for medical information about my child to be shared with appropriate staff members with the exceptions listed below:

_____ I ask that no medical information about my child be shared with staff members.

Parent/Guardian Signature

Date

THE CRAIG SCHOOL EMERGENCY INFORMATION FORM

Student's Name: _____ DOB: _____ Student's Grade: _____

Parent #1: _____ Parent #2: _____

Home Address: _____

Home Phone: _____ Primary Email: _____

Parent #1 Work Phone: _____ Parent #2 Work Phone: _____

Parent #1 Cell Phone: _____ Parent #2 Cell Phone: _____

Contact Person if parents unavailable: _____ Relationship to student: _____

Contact Person Address: _____ Cell Phone #: _____

Doctor's Name: _____ Phone #: _____

Hospital Affiliation: _____ Address: _____

List any and all prescription medications you give to your child including dosages & times: _____

Allergies: _____

Other relevant emergency medical information (e.g. past medical history):

Date of last physical exam: _____

Does this child have any health insurance including NJ Family Care/Medicare, Medicare, private or other?

If YES, name of insurance company: _____

If NO, NJ FamilyCare provides free or low-cost health insurance for uninsured children and certain low-income parents. For more information call 1-800-701-0710 or visit www.njfamilycare.org to apply online. Craig School may release my name and address to the NJ FamilyCare Program to contact me about health insurance:

Signature: _____ Printed Name: _____ Date: _____

Written Consent required pursuant to 20 U.S.C. 1232g (b)(1) and 34 C.F.R. 99.30 (b)

***If any information changes during the school year or summer program, please email the office or send a note.*

In case of medical emergency, I will be called. In the event a parent or guardian cannot be reached, I agree that The Craig School staff will make any medical decision deemed necessary. I agree to assume the financial responsibility for such emergency treatment.

Signature of Parent or Guardian *Printed Name* *Date*

NOTE: THIS FORM MUST BE COMPLETED FOR ALL STUDENTS AND RETURNED PRIOR TO THE START OF SCHOOL



1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA PARENT/GUARDIAN CONCUSSION POLICY ACKNOWLEDGMENT FORM

In order to help protect the student athletes of New Jersey, the NJSIAA has mandated that all athletes, parents/guardians and coaches follow the NJSIAA Concussion Policy.

A concussion is a brain injury and all brain injuries are serious. They may be caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child/player reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

1. Headache.
2. Nausea/vomiting.
3. Balance problems or dizziness.
4. Double vision or changes in vision.
5. Sensitivity to light or sound/noise.
6. Feeling of sluggishness or fogginess.
7. Difficulty with concentration, short-term memory, and/or confusion.
8. Irritability or agitation.
9. Depression or anxiety.
10. Sleep disturbance.

Signs observed by teammates, parents and coaches include:

1. Appears dazed, stunned, or disoriented.
2. Forgets plays or demonstrates short-term memory difficulties (e.g. is unsure of the game, score, or opponent)
3. Exhibits difficulties with balance or coordination.
4. Answers questions slowly or inaccurately.
5. Loses consciousness.
6. Demonstrates behavior or personality changes.
7. Is unable to recall events prior to or after the hit.

What can happen if my child/player keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

If you think your child/player has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear. Close observation of the athlete should continue for several hours.

An athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and may not return to play until the athlete is evaluated by a medical doctor or doctor of Osteopathy, trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider.

You should also inform you child's Coach, Athletic Trainer (ATC), and/or Athletic Director, if you think that your child/player may have a concussion. And when it doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/ConcussionInYouthSports/>

www.nfhslearn.com

_____ Signature of Student-Athlete	_____ Print Student-Athlete's Name	_____ Date
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_____ Signature of Parent/Guardian	_____ Print Parent/Guardian's Name	_____ Date
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Please keep this form on file at the school. Do not return to the NJSIAA. Thank you.

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: _____

Website Resources

- Sudden Death in Athletes
<http://tinyurl.com/m2gjmvaq>
- 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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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

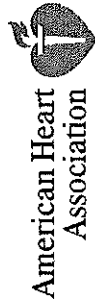
Revised 2014: Nancy Curry, EdM;
Christine DeWitt-Parker, MSN, CSN, RN;
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SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

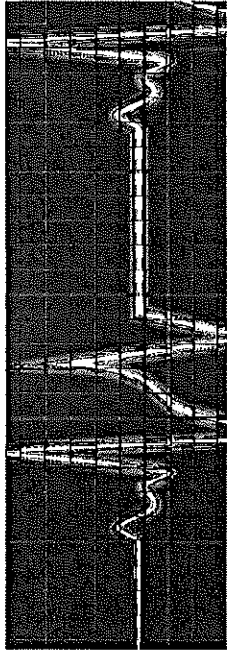
The Basic Facts on
Sudden Cardiac Death
in Young Athletes



American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

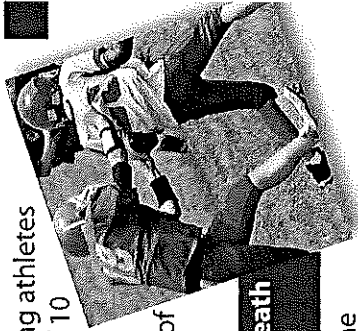


Learn and Live



SUDDEN CARDIAC DEATH

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?

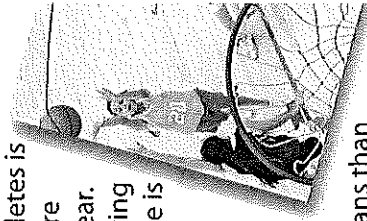


What is sudden cardiac death in the young athlete?

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 (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 Preparation 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