



# DR. RONALD E. MCNAIR ACADEMIC HIGH SCHOOL

123 Coles Street  
Jersey City, New Jersey 07302



N.J. Monthly Magazine Ranked Top 2%  
Edward Slattery, Principal  
P: (201) 418-7819  
F: (201) 792-3013

U.S. News & World Report Ranked 43<sup>rd</sup>

Newsweek Ranked Top 6%  
Alice Barone, Vice-Principal  
P: (201) 878-4804  
F: (201) 792-1498

## Instructions for Sports Physicals

Parent/Guardian must complete and sign the history form. Please answer all questions. Student must sign the form as well.

Parent/Guardian must complete and sign the supplemental form. Student must sign as well.

Physician must complete, sign and stamp the physical examination form.  
Please do not forget to document vision, blood pressure and pulse.

If your child has asthma, your physician must complete the asthma treatment plan.

The parent and student must sign the consent forms for permission to play, random drug screening and concussion education acknowledgement.

Please sign the parent/guardian acknowledgement form for Sudden Cardiac Death and retain the brochure for your records.

**Any incomplete forms will be returned**

Return all completed physicals to the Athletic Trainer **AFTER SCHOOL** in room B5.

**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?		
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>	<b>Yes</b>	<b>No</b>	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 MRSA 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?		
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>	<b>Yes</b>	<b>No</b>	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 sickle cell trait 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?		
<b>BONE AND JOINT QUESTIONS</b>	<b>Yes</b>	<b>No</b>	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 dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, 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?			<b>FEMALES ONLY</b>		
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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**NOTE:** The preparticipation physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practitioner 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 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP / ( / )	Pulse	Vision R 20/	L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • 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* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>†</sup>			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic <sup>‡</sup>			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
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 GU exam if in private setting. Having third party present is recommended.  
 ‡Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

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

- Not cleared  
 Pending further evaluation  
 For any sports  
 For certain sports \_\_\_\_\_  
 Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

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

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

# ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

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

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

- Not cleared
- Pending further evaluation
  - For any sports
  - For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_\_

# 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

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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

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# Asthma Treatment Plan

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)

The Pediatric/Adult  
Asthma Coalition  
of New Jersey  
Your Pathway to Asthma Control  
PACNJ approved Plan available at  
www.pacrj.org

Sponsored by  
**AMERICAN  
LUNG  
ASSOCIATION.**  
IN NEW JERSEY



(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)		Emergency Contact
Phone	Phone	Phone	

## HEALTHY



You have **all** of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above \_\_\_\_\_

**Take daily medicine(s). Some metered dose inhalers may be more effective with a "spacer" - use if directed**

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500 _____	1 inhalation twice a day
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230 _____	2 puffs MDI twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220 _____	2 puffs MDI twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250 _____	1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0 _____	1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Singulair <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg _____	1 tablet daily
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Other _____	
<input type="checkbox"/> None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine \_\_\_\_\_ minutes before exercise.

## CAUTION



You have **any** of these:

- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: \_\_\_\_\_

And/or Peak flow from \_\_\_\_\_ to \_\_\_\_\_

**Continue daily medicine(s) and add fast-acting medicine(s).**

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg _____	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil® _____	2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex® _____	2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Xopenex® <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other _____	

➡ If fast-acting medicine is needed more than 2 times a week, except before exercise, then call your doctor.

## EMERGENCY



Your asthma is getting worse fast:

- Fast-acting medicine did not help within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue

And/or Peak flow below \_\_\_\_\_

**Take these medicines NOW and call 911. Asthma can be a life-threatening illness. Do not wait!**

<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg _____	1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil® _____	2 puffs MDI every 20 minutes
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex® _____	2 puffs MDI every 20 minutes
<input type="checkbox"/> Xopenex® <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 20 minutes
<input type="checkbox"/> Other _____	

## Triggers

Check all items that trigger patient's asthma:

- Chalk dust
- Cigarette Smoke & second hand smoke
- Colds/Flu
- Dust mites, dust, stuffed animals, carpet
- Exercise
- Mold
- Ozone alert days
- Pests - rodents, cockroaches
- Pets - animal dander
- Plants, flowers, cut grass, pollen
- Strong odors, perfumes, cleaning products, scented product
- Sudden temperature change
- Wood Smoke
- Foods: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- Other: \_\_\_\_\_

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

REVISED MAY 2009  
Prescription for \_\_\_\_\_  
www.pacrj.org

### FOR MINORS ONLY:

- This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
- This student is not approved to self-medicate.

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.

PHYSICIAN/APWP/PA SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PHYSICIAN STAMP

*J. J. J. H. H.*

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

## NJSIAA STEROID TESTING POLICY

### CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Print Student-Athlete's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Print Parent/Guardian's Name

\_\_\_\_\_  
Date

**JERSEY CITY PUBLIC SCHOOLS**  
**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 foginess
- 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 too soon?**

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

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

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

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

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

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

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

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

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

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

[www.a50j.org](http://www.a50j.org)

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Print Student-Athlete's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Print Parent/Guardian's Name

\_\_\_\_\_  
Date



Jersey City Public Schools  
Department of Athletics

346 Claremont Ave  
Jersey City, NJ 07305

**CONSENT FORM FOR INTERSCHOLASTIC ATHLETICS**

With my full knowledge and consent \_\_\_\_\_  
may participate in all physical activities and may take trips that are part of this program.

The school authorities will exercise maximum care in the administration and control of athletic activities  
in order to safeguard participants against injury and accident.

Realizing that such activity involves the potential for injury, which is inherent in all sports, I/we  
acknowledge that even with the best coaching, use of the most advanced protective equipment and  
strict observances of the rules, injuries are still a possibility. On rare occasions these injuries can be so  
severe as to result in total disability, paralysis, or even death. I/we acknowledge that I/we have read and  
understand this warning.

In the event of an injury to my child I give consent as parent/guardian to have my child assessed and  
treated by a certified Athletic Trainer. I also give my permission for disclosure of medical information  
regarding my child and any treatment necessary in the event of a medical emergency.

I certify that the information provided herein is accurate as of the date of these signatures.

Parent/Guardian (Signature): \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (Print Name): \_\_\_\_\_

Student (Signature): \_\_\_\_\_ Date: \_\_\_\_\_

Student (Print Name): \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Phone Numbers:

Primary: \_\_\_\_\_ Relationship: \_\_\_\_\_

Secondary: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physician Information:

Providers Name: \_\_\_\_\_

Providers Phone Number: \_\_\_\_\_

Providers Address: \_\_\_\_\_

I DO NOT HAVE A PROVIDER: \_\_\_\_\_ (Please check if applicable)

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: \_\_\_\_\_

## Website Resources

- Sudden Death in Athletes  
[www.cardiachealth.org/sudden-death-in-athletes](http://www.cardiachealth.org/sudden-death-in-athletes)
- Hypertrophic Cardiomyopathy Association  
[www.hfcm.org](http://www.hfcm.org)
- American Heart Association [www.heart.org](http://www.heart.org)

## Collaborating Agencies:

American Academy of Pediatrics  
New Jersey Chapter  
3836 Quakerbridge Road, Suite 108  
Hamilton, NJ 08619  
(p) 609-642-0014  
(f) 609-642-0015  
[www.aapnj.org](http://www.aapnj.org)

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

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

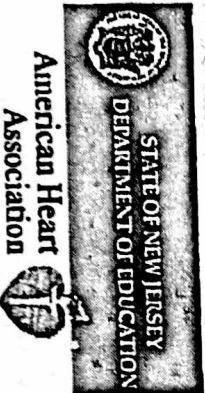
New Jersey Department of Health  
P. O. Box 360  
Trenton, NJ 08625-0360  
(p) 609-292-7837  
[www.state.nj.us/health](http://www.state.nj.us/health)

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# SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

The Basic Facts on  
Sudden Cardiac Death  
in Young Athletes



## SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

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

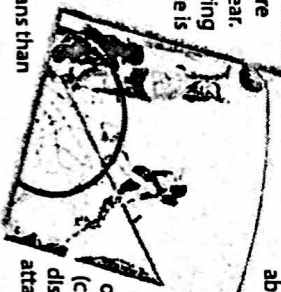
**What is sudden cardiac death in the young athletes?**

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

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

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

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



**What are the most common causes?**

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

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

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

## SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

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

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

### Are there warning signs to watch for?

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

- Fainting, a seizure or convulsions during physical activity;
- Fainting or a seizure from emotional excitement, emotional distress or being startled;
- Dizziness or lightheadedness, especially during exertion;
- Chest pains, at rest or during exertion;

- Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation;
- Fatigue or tiring more quickly than peers; or
- Being unable to keep up with friends due to shortness of breath.

### 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.

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

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

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

Effective September 1, 2014, the New Jersey Department of Education requires that all public and nonpublic schools grades K through 12 shall:

- Have an AED available at every sports event (three minutes total time to reach and return with the AED);
- Have adequate personnel who are trained in AED use present at practices and games;
- Have coaches and athletic trainers trained in basic life support techniques (CPR); and
- Call 911 immediately while someone is retrieving the AED.