FORM B - NIAA PRE-PARTICIPATION HISTORY FORM
(COMPLETED THE ATHLETE’S FIRST AND THIRD YEARS OF PARTICIPATION WITH PHYSICAL)

HISTORY

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.

1. Do you have a chronic medical condition (asthma, diabetes, high blood pressure, etc.)?
   YES    NO

2. Have you ever been hospitalized overnight?
   YES    NO

3. Are you currently taking any prescriptions or non-prescriptions (over-the-counter) medications or pills or using an inhaler?
   YES    NO

4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
   YES    NO

5. a. Have you passed out or been dizzy during exercise?
    YES    NO

   b. Have you had chest pain (or pressure) with exercise?
    YES    NO

   c. Have you had excessive unexplained shortness of breath or fatigue with exercise?
    YES    NO

   d. Is there a family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50?
    YES    NO

   e. Is there a history in your family of hypertrophic cardiomyopathy, dilated cardiomyopathy long QT syndrome or Marfan’s syndrome?
    YES    NO

   f. Has a physician denied or restricted your participation in sports for any heart problem?
    YES    NO

6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?
   YES    NO

7. a. Have you had a head injury or concussion?
    YES    NO

   b. Have you been knocked out, become unconscious, or lost your memory?
    YES    NO

   c. Have you had a seizure?
    YES    NO

   d. Do you have frequent or severe headaches?
    YES    NO

   e. Have you had numbness or tingling in your arms, hands, legs, or feet?
    YES    NO

8. Have you become ill from exercising in the heat?
   YES    NO

9. Do you cough, wheeze, or have trouble breathing during or after activity?
   YES    NO
10. a. Do you use any special protective or corrective equipment or devices that aren’t usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?

   YES  NO

   b. Are you missing an eye, kidney, testicle or ovary?

11. a. Have you had any problems with your eyes or vision?

   YES  NO

   b. Do you wear glasses, contacts or protective eyewear?

12. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?

   YES  NO

   If yes, check appropriate item and explain below:

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

13. Are you actively trying to gain or lose weight?

   YES  NO

14. Would you like to talk to someone about stress, anger, depression, or other issues?

   YES  NO

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?  ______________________________

17. When was your most recent menstrual period?  _______________________

18. How much time do you usually have from the start of one period to the start of another?  ________________

19. How many periods have you had in the last year?  ________________

20. 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  Signature of Parent/Guardian  Date
FORM C

Dear Health Practitioner:

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

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

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

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

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

- Excessive shortness of breath, syncope or chest pain during exercise.
- Family history of premature death or cardiovascular morbidity. (Before age 50)
- Family history of HCM, dilated 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
References:


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
5. Arm span greater than height
6. Upper to lower body ration more than one standard deviation below the mean
7. Myopia
8. Ectopic lens

*This finding alone should prompt further investigation.

FORM D -- Health Practitioner, please refer to the letter & references provided on Form C.
NIAA PRE-PARTICIPATION PHYSICAL EVALUATION
(Physical to be completed during an athlete’s first and third year of participation)

<table>
<thead>
<tr>
<th>PHYSICAL EXAMINATION</th>
<th>DATE OF EXAMINATION:</th>
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<tbody>
<tr>
<td>NAME: __________________________</td>
<td>DATE OF BIRTH: __________________________</td>
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</tbody>
</table>

| HEIGHT: ____________________ | WEIGHT: __________ | % BODY FAT (optional): ______ | PULSE: __________ | BP: _____/_____ (_____/____, ____/____) |

| VISION: R 20/____ | L 20/____ | CORRECTED: Y / N | PUPILS: Equal _______ Unequal _______ |

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL / ABSENT</th>
<th>ABNORMAL FINDINGS</th>
<th>EXPLAIN</th>
<th>INITIALS</th>
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</thead>
<tbody>
<tr>
<td>Appearance</td>
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<tr>
<td>Eyes/Ears/Nose/Throat</td>
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<tr>
<td>Lymph Nodes</td>
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<td>Lungs</td>
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<td>Abdomen</td>
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<td>Genitalia (Males Only)</td>
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<tr>
<td>Skin</td>
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**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: ____________________________________________

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<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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</table>

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