

Sudden Cardiac Arrest

Symptoms and Warning Signs

What is Sudden Cardiac Arrest (SCA)?

SCA is a life-threatening emergency that occurs when the heart suddenly and unexpectedly stops beating. This causes blood and oxygen to stop flowing to the rest of the body. The individual will not have a pulse. It can happen without warning and can lead to death within minutes if the person does not receive immediate help. Only **1 in 10** survives SCA. If Cardiopulmonary Resuscitation (CPR) is given and an Automatic External Defibrillator (AED) is administered early, **5 in 10** could survive.



SCA is NOT a heart attack, which is caused by reduced or blocked blood flow to the heart. However, a heart attack can increase the risk for SCA.

Watch for Warning Signs

SCA usually happens without warning. SCA can happen in young people who don't know they have a heart problem, and it may be the first sign of a heart problem. When there are warning signs, the person may experience:



If any of these warning signs are present, it's important to talk with a health care provider. There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops due to SCA, blood stops flowing to the brain and other body organs. Death or permanent brain damage can occur in minutes.

Electrocardiogram (EKG) Testing

EKG is a noninvasive, quick, and painless test that looks at the heart's electrical activity. Small electrodes attached to the skin of the arms, legs, and chest capture the heartbeat as it moves through the heart. An EKG can detect some heart problems that may lead to an increased risk of SCA. Routine EKG testing is not currently recommended by national medical organizations, such as the American Academy of Pediatrics and the American College of Cardiology, unless the pre-participation physical exam reveals an indication for this test. The student or parent may request, from the student's health care provider, an EKG be administered in addition to the student's pre-participation physical exam, at a cost to be incurred by the student or the student's parent.



Limitations of EKG Testing

- An EKG may be expensive and cannot detect all conditions that predispose an individual to SCA.

- False positives (abnormalities identified during EKG testing that turn out to have no medical significance) may lead to unnecessary stress, additional testing, and unnecessary restriction from athletic participation.
- Accurate EKG interpretation requires adequate training.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete

Print Student-Athlete's Name

Date

Signature of Parent/Guardian

Print Parent/Guardian's Name

Date

CONCUSSION

INFORMATION AND SIGNATURE FORM FOR STUDENT-ATHLETES & PARENTS/LEGAL GUARDIANS

(Adapted from CDC “Heads Up Concussion in Youth Sports”)

Public Chapter 148, effective January 1, 2014, requires that school and community organizations sponsoring youth athletic activities establish guidelines to inform and educate coaches, youth athletes and other adults involved in youth athletics about the nature, risk and symptoms of concussion/head injury.

Read and keep this page.
Sign and return the signature page.

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a “ding,” “getting your bell rung” or what seems to be a mild bump or blow to the head can be serious.

Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports **one or more** symptoms of concussion listed below after a bump, blow or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care provider* says s/he is symptom-free and it’s OK to return to play.

SIGNS OBSERVED BY COACHING STAFF	SYMPTOMS REPORTED BY ATHLETES
Appears dazed or stunned	Headache or “pressure” in head
Is confused about assignment or position	Nausea or vomiting
Forgets an instruction	Balance problems or dizziness
Is unsure of game, score or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness, even briefly	Feeling sluggish, hazy, foggy or groggy
Shows mood, behavior or personality changes	Concentration or memory problems
Can’t recall events <i>prior</i> to hit or fall	Confusion
Can’t recall events <i>after</i> hit or fall	Just not “feeling right” or “feeling down”

*Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention after a bump, blow or jolt to the head or body if s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (*even a brief loss of consciousness should be taken seriously*)

WHY SHOULD AN ATHLETE REPORT HIS OR HER SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brains. *They can even be fatal.*

Remember:

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care provider* says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration such as studying, working on the computer or playing video games may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

* Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training.

Student-athlete & Parent/Legal Guardian Concussion Statement

Must be **signed and returned** to school or community youth athletic activity prior to participation in practice or play.

Student-Athlete Name: _____

Parent/Legal Guardian Name(s): _____

After reading the information sheet, I am aware of the following information:

Student-Athlete initials		Parent/Legal Guardian initials
	A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a <i>health care provider*</i> to return to play or practice after a concussion.	
	Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.	
	After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away.	
	Sometimes repeat concussion can cause serious and long-lasting problems and even death.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

** Health care provider* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

Signature of Student-Athlete

Date

Signature of Parent/Legal guardian

Date

To student athletes and their parents/caregivers:

Before you can play a sport the TSSAA (Tennessee Secondary School Athletic Association) says you must get a sport's physical. This is also called a PPE (Preparticipation Physical Evaluation). The PPE promotes the health and well-being of athletes as they train and compete. It also helps keep athletes safe as they play sports. It is NOT meant to stop them from playing.

Where can you go to get a PPE? In the newest PPE guidebook, the groups below say your doctor's office or the place where you get your medical care is where you can go to get it done:

- the American Academy of Pediatrics,
- the American Academy of Family Physicians,
- the American College of Sports Medicine,
- the American Medical Society for Sports Medicine,
- the American Orthopedic Society for Sports Medicine,
- and the American Osteopathic Academy of Sports Medicine.
- It's also endorsed by the National Athletic Trainers' Association and the National Federation of State High School Associations.

There are other places you can get a PPE, but **we recommend athletes get a PPE during their Well Visit at their doctor's office or School Based Health Center.** This ensures exams cover everything important about your overall health and well-being. It also limits absences from school and sports.

We encourage you to work the PPE into the routine health care you get at your doctor's office or the place where you get your medical care. If you're enrolled in TennCare your well visits are free.

Sincerely,

Tennessee Secondary School Athletic Association
Tennessee Chapter of the American Academy of Pediatrics
Tennessee Division of TennCare

Do you have TennCare and need to know who your doctor is? You can call your MCO at:

Amerigroup: 1-800-600-4441

BlueCare: 1-800-468-9698

UnitedHealthcare: 1-800-690-1606

TennCareSelect: 1-800-263-5479

This form should be placed into the athlete's medical file and should **not** be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

Have you had COVID-19? (check one): Y N

Have you been immunized for COVID-19? (check one): Y N If yes, have you had: One shot Two shots

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)			Yes	No
1. Do you have any concerns that you would like to discuss with your provider?				
2. Has a provider ever denied or restricted your participation in sports for any reason?				
3. Do you have any ongoing medical issues or recent illness?				
HEART HEALTH QUESTIONS ABOUT YOU			Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?				
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?				
7. Has a doctor ever told you that you have any heart problems?				
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.				

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)			Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?				
10. Have you ever had a seizure?				
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?				
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?				
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?				

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
COVID-19 VACCINE		
Previously received COVID-19 vaccine: <input type="checkbox"/> Y <input type="checkbox"/> N		
Administered COVID-19 vaccine at this visit: <input type="checkbox"/> Y <input type="checkbox"/> N If yes: <input type="checkbox"/> First dose <input type="checkbox"/> Second dose		
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 		

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

- Medically eligible for certain sports

- Not medically eligible pending further evaluation

- Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

*Entire Page Completed By Patient

Athlete Information

Last Name _____ First Name _____ MI _____

Sex: [] Male [] Female Grade _____ Age _____ DOB ____/____/____

Allergies _____

Medications _____

Insurance _____ Policy Number _____

Group Number _____ Insurance Phone Number _____

Emergency Contact Information

Home Address _____ (City) _____ (Zip) _____

Home Phone _____ Mother's Cell _____ Father's Cell _____

Mother's Name _____ Work Phone _____

Father's Name _____ Work Phone _____

Another Person to Contact _____

Phone Number _____ Relationship _____

Legal/Parent Consent

I/We hereby give consent for (athlete's name) _____ to represent (name of school) _____ in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. ***On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We further grant permission to the school and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the student athlete named above during or resulting from participation in athletics.*** By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, ***I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.***

Signature of Athlete

Signature of Parent/Guardian

Date

CONSENTIMIENTO A PARTICIPAR EN ACTIVIDADES ATLETICAS Y RECIBIR CUIDADO MEDICO SI FUERA NECESASRIO

(Este Consentimiento debe ser completado por el Estudiante-Aleta y sus padres o guardianes.)

Información del Estudiante-Aleta

Apellido _____ Nombre _____ SN _____

Sexo: [] Varón [] Hembra Grado _____ Edad _____ Fecha de Nacimiento ____ / ____ / ____

Alergias _____

Medicaciones _____

Seguro Médico _____ Número de la Póliza _____

Número del Grupo _____ Teléfono del Seguro _____

Información del Contacto en Caso de Emergencia

Dirección de Casa _____ (Ciudad) _____

(Código Postal) _____

Teléfono de Casa _____ Celular de la Madre o Guardian _____

Celular del Padre o Guardian _____

Nombre de la Madre o Guardian _____ Teléfono del Trabajo _____

Nombre del Padre o Guardian _____ Teléfono del Trabajo _____

Otra Persona Contacto _____

Número de Teléfono _____ Relación _____

Consentimiento Legal de los Padres o Guardianes

Yo/Nosotros damos nuestro consentimiento para que (nombre del Estudiante-Aleta) _____ pueda representar (nombre de la escuela) _____ en deportes y que yo/nosotros entendemos que esa actividad lleva la posibilidad de sufrir lesiones. Yo/Nosotros sabemos que aún con el mejor entrenamiento, los mejores artículos deportivos, y la observación estricta de las reglas, es posible sufrir lesiones. **En algunas ocasiones, estas lesiones son severas y pueden resueltar en incapacidad, parálisis, y hasta la muerte. Yo/Nosotros damos permiso a la escuela y a TSSAA, sus médicos, entrenadores atléticos, y/o técnicos médicos de emergencias a dar ayuda, tratamiento, cuidado médico o quirúrgico considerados necesarios para la salud y bienestar del Estudiante-Aleta nombrado arriba durante o como resultado de su participación en los deportes.** Al firmar este consentimiento, el Estudiante-Aleta nombrado arriba y sus padres/guardianes consienten a que los profesionales de la salud conduzcan un chequeo, examinación, y pruebas del Estudiante-Aleta durante la examinación pre-participatoria y a obtener la historia médica. Entendemos que los profesionales de la salud que conduzcan estas pruebas y evaluaciones van a anotar los resultados y observaciones en los formularios y records que acompañan este documento. Como padre o guardian , **yo/nosotros entendemos que somos totalmente responsables por cualquier asunto legal que pueda resultar de las acciones personales del Estudiante-Aleta nombrado arriba.**

Firma del Estudiante-Aleta

Firma del Padre/Guardian

Fecha

Este formulario debe colocarse en el expediente médico del atleta y no debe compartirse con escuelas u organizaciones deportivas. El formulario de elegibilidad médica es el único formulario que debe enviarse a una escuela u organización deportiva.

Aviso legal: Los atletas que tengan una evaluación física de preparparticipación vigente en el archivo (según los lineamientos generales estatales y locales) no necesitan completar otro formulario de antecedentes.

■ EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN (orientación provisional)

FORMULARIO DE HISTORIAL CLÍNICO

Nota: Complete y firme este formulario (con la supervisión de sus padres si es menor de 18 años) antes de acudir a su cita.

Nombre: _____ Fecha de nacimiento: _____

Fecha del examen médico: _____ Deporte(s): _____

Sexo que se le asignó al nacer (F, M o intersexual): _____ ¿Con cuál género se identifica? (F, M u otro): _____

¿Ha tenido COVID-19? (elija una opción) Sí No

¿Ha recibido la vacuna contra el COVID-19? (elija una opción): Sí No Si la respuesta es sí, usted recibió: Una dosis Dos dosis

Mencione los padecimientos médicos pasados y actuales que haya tenido. _____

¿Alguna vez se le practicó una cirugía? Si la respuesta es afirmativa, haga una lista de todas sus cirugías previas. _____

Medicamentos y suplementos: Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume. _____

¿Sufre de algún tipo de alergia? Si la respuesta es afirmativa, haga una lista de todas sus alergias (por ejemplo, a algún medicamento, al polen, a los alimentos, a las picaduras de insectos). _____

Cuestionario sobre la salud del paciente versión 4 (PHQ-4)

Durante las últimas dos semanas, ¿con qué frecuencia experimentó alguno de los siguientes problemas de salud? (Encierre en un círculo la respuesta)

	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
Se siente nervioso, ansioso o inquieto	0	1	2	3
No es capaz de detener o controlar la preocupación	0	1	2	3
Siente poco interés o satisfacción por hacer cosas	0	1	2	3
Se siente triste, deprimido o desesperado	0	1	2	3

(Una suma ≥ 3 se considera positiva en cualquiera de las subescalas, [preguntas 1 y 2 o preguntas 3 y 4] a fin de obtener un diagnóstico).

PREGUNTAS GENERALES (Dé una explicación para las preguntas en las que contestó "Sí", en la parte final de este formulario. Encierre en un círculo las preguntas si no sabe la respuesta).		
	Sí	No
1. ¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos?		
2. ¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo?		
3. ¿Padece algún problema médico o enfermedad reciente?		
PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR		
	Sí	No
4. ¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio?		

PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR (CONTINUACIÓN)		
	Sí	No
5. ¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio?		
6. ¿Alguna vez sintió que su corazón se aceleraba, palpitaba en su pecho o latía intermitentemente (con latidos irregulares) mientras hacía ejercicio?		
7. ¿Alguna vez un médico le dijo que tiene problemas cardíacos?		
8. ¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electrocardiografía (ECG) o ecocardiografía.		
9. Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos?		
10. ¿Alguna vez tuvo convulsiones?		

PREGUNTAS SOBRE LA SALUD CARDIOVASCULAR DE SU FAMILIA		Sí	No
11.	¿Alguno de los miembros de su familia o pariente murió debido a problemas cardíacos o tuvo una muerte súbita e inesperada o inexplicable antes de los 35 años de edad (incluyendo muerte por ahogamiento o un accidente automovilístico inexplicables)?		
12.	¿Alguno de los miembros de su familia padece un problema cardíaco genético como la miocardiopatía hipertrófica (HCM), el síndrome de Marfan, la miocardiopatía arritmogénica del ventrículo derecho (ARVC), el síndrome del QT largo (LQTS), el síndrome del QT corto (SQTS), el síndrome de Brugada o la taquicardia ventricular polimórfica catecolaminérgica (CPVT)?		
13.	¿Alguno de los miembros de su familia utilizó un marcapasos o se le implantó un desfibrilador antes de los 35 años?		
PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES		Sí	No
14.	¿Alguna vez sufrió una fractura por estrés o una lesión en un hueso, músculo, ligamento, articulación o tendón que le hizo faltar a una práctica o juego?		
15.	¿Sufre alguna lesión ósea, muscular, de los ligamentos o de las articulaciones que le causa molestia?		
PREGUNTAS SOBRE CONDICIONES MÉDICAS		Sí	No
16.	¿Tose, sibila o experimenta alguna dificultad para respirar durante o después de hacer ejercicio?		
17.	¿Le falta un riñón, un ojo, un testículo (en el caso de los hombres), el bazo o cualquier otro órgano?		
18.	¿Sufre dolor en la ingle o en los testículos, o tiene alguna protuberancia o hernia dolorosa en la zona inguinal?		
19.	¿Padece erupciones cutáneas recurrentes o que aparecen y desaparecen, incluyendo el herpes o Staphylococcus aureus resistente a la meticilina (MRSA)?		

PREGUNTAS SOBRE CONDICIONES MÉDICAS (CONTINUACIÓN)		Sí	No
20.	¿Alguna vez sufrió un traumatismo craneoencefálico o una lesión en la cabeza que le causó confusión, un dolor de cabeza prolongado o problemas de memoria?		
21.	¿Alguna vez sintió adormecimiento, hormigueo, debilidad en los brazos o piernas, o fue incapaz de mover los brazos o las piernas después de sufrir un golpe o una caída?		
22.	¿Alguna vez se enfermó al realizar ejercicio cuando hacía calor?		
23.	¿Usted o algún miembro de su familia tiene el rasgo drepanocítico o padece una enfermedad drepanocítica?		
24.	¿Alguna vez tuvo o tiene algún problema con sus ojos o su visión?		
25.	¿Le preocupa su peso?		
26.	¿Está tratando de bajar o subir de peso, o alguien le recomendó que baje o suba de peso?		
27.	¿Sigue alguna dieta especial o evita ciertos tipos o grupos de alimentos?		
28.	¿Alguna vez sufrió un desorden alimenticio?		
ÚNICAMENTE MUJERES		Sí	No
29.	¿Ha tenido al menos un periodo menstrual?		
30.	¿A los cuántos años tuvo su primer periodo menstrual?		
31.	¿Cuándo fue su periodo menstrual más reciente?		
32.	¿Cuántos periodos menstruales ha tenido en los últimos 12 meses?		

Proporcione una explicación aquí para las preguntas en las que contestó "Sí".

Por la presente declaro que, según mis conocimientos, mis respuestas a las preguntas de este formulario están completas y son correctas.

Firma del atleta: _____

Firma del padre o tutor: _____

Fecha: _____