

Sudden Cardiac Arrest (SCA) Parent/Guardian Letter

Date 1/18/23

Dear Parents/Guardians,

The Dominic Murray Sudden Cardiac Arrest Prevention Act is a new law as of July 1, 2022 for schools (pre-12<sup>th</sup> grade in New York State. This law requires schools, students, and parents/guardians have information on sudden cardiac arrest risks, signs, and symptoms. Please note that sudden cardiac arrest in children and youth is rare. The incidence of sudden cardiac death (SCD) on the playing field is 0.61 in 100,000.<sup>1</sup>

The Niagara Erie Youth Sports Association, Inc. (NEYSA) has adopted the requirements of the Dominic Murray Sudden Cardiac Arrest Prevention Act for all of the NEYSA member organizations as well as all NEYSA sanctioned activities.

Sudden Cardiac Arrest (SCA) is an emergency that happens when the heart suddenly stops working. SCA can cause death if not treated immediately, and even with treatment death may occur. Immediate treatment is cardiopulmonary resuscitation (CPR) and use of an automatic external defibrillator (AED). All NEYSA member organizations must have volunteers trained in the use of CPR and AED at all NEYSA sanctioned events, including practices, scrimmages and games.

Preventing SCA before it happens is the best way to save a life<sup>1</sup>. Both your family health history and your child's personal history must be told to healthcare providers to help them know if your child is at risk for sudden cardiac arrest. Ask your child if they are having any of the symptoms listed below and tell a healthcare provider. Know your family history and tell a healthcare provider of any risk factors listed below.

**The signs or symptoms are:**

- Fainting or seizure, especially during or right after exercise or with excitement or startled
- Racing heart, palpitations, or irregular heartbeat
- Dizziness, lightheadedness, or extreme fatigue with exercise
- Chest pain or discomfort with exercise
- Excessive shortness of breath during exercise
- Excessive, unexpected fatigue during or after exercise

**Student's Personal Risk Factors are:**

- Use of diet pills, performance-enhancing supplements, energy drinks, or drugs such as cocaine, inhalants, or "recreational" drugs.<sup>2</sup>
- Elevated blood pressure or cholesterol
- History of health care provider ordered test(s) for heart related issues

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<sup>1</sup> Maron BJ, Doerer JJ, Haas TS, et al. Sudden deaths in young competitive athletes: analysis of 1866 deaths in the United States, 1980-2006. *Circulation* 2009;119:1085-92. 10.1161/CIRCULATIONAHA.108.804617

<sup>2</sup> SCA Prevention Toolkit – Eric Paredes Save A Life Foundation ([epsavealife.org](http://epsavealife.org))

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**Student's Family History Risk Factors are:**

- Family history of known heart abnormalities or sudden death before 50 years of age
- Family members with *unexplained* fainting, seizures, drowning, near drowning or car accidents before 50 years of age
- Structural heart abnormality, repaired or unrepaired
- Any relative diagnosed with the following conditions:
  - Enlarged Heart/ Hypertrophic Cardiomyopathy/Dilated Cardiomyopathy
  - Arrhythmogenic Right Ventricular Cardiomyopathy
  - Heart rhythm problems, long or short QT interval
  - Brugada Syndrome
  - Catecholaminergic Ventricular Tachycardia
  - Marfan Syndrome- aortic rupture
  - Heart attack at 50 years or younger
  - Pacemaker or implanted cardiac defibrillator (ICD)

SCA in athletes at risk can be triggered by athletic activities. To decrease any chance of SCA in a child, the Interval Health History for Athletics must be completed and signed by a parent/guardian before each sports season unless a physical examination has been conducted within 30 days before the start of the season. This form has questions to help identify changes since the last physical examination or health history was completed. NEYSA member organizations' personnel may require a participant with health or history changes to see a healthcare provider before participating in athletics.

Finally, NEYSA's member organizations' Emergency Action Programs (EAP) should require any participant who has signs and symptoms of pending SCA be removed from athletic activity until seen by a **physician**. The physician must provide written clearance to the NEYSA member organization's leadership for the participant to be able to return to athletics.

# NEYSA's Interval Health History for Athletics

Athlete's Name:		DOB:
Organization's Name:		Age:
Team Name:	Limitations: <input type="checkbox"/> NO <input type="checkbox"/> YES	
Sport:	Date of last Health Exam:	
Team Level: <input type="checkbox"/> Mini <input type="checkbox"/> Freshman <input type="checkbox"/> JV <input type="checkbox"/> Varsity	Date form completed:	
<b>MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.</b>		

DOES OR HAS YOUR CHILD		
GENERAL HEALTH	NO	YES
Ever been restricted by a health care provider from sports participation for any reason?		
Ever had surgery?		
Ever spent the night in a hospital?		
Been diagnosed with mononucleosis within the last month?		
Have only one functioning kidney?		
Have a bleeding disorder?		
Have any problems with hearing or have congenital deafness?		
Have any problems with vision or only have vision in one eye?		
Have an ongoing medical condition?		
If yes, check all that apply:		
<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle cell trait or disease <input type="checkbox"/> Other:		
Have Allergies?		
If yes, check all that apply		
<input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other:		
Ever had anaphylaxis?		
Carry an epinephrine auto-injector?		
BRAIN/HEAD INJURY HISTORY	NO	YES
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?		
Receive treatment for a seizure disorder or epilepsy?		
Ever had headaches with exercise?		
Ever had migraines?		

DOES OR HAS YOUR CHILD		
BREATHING	NO	YES
Ever complained of getting extremely tired or short of breath during exercise?		
Use or carry an inhaler or nebulizer?		
Wheeze or cough frequently during or after exercise?		
Ever been told by a health care provider they have asthma or exercise-induced asthma?		
DEVICES / ACCOMMODATIONS	NO	YES
Use a brace, orthotic, or another device?		
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?		
Wear protective eyewear, such as goggles or a face shield?		
Wear a hearing aid or cochlear implant?		
<b>Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.</b>		
DIGESTIVE (GI) HEALTH	NO	YES
Have stomach or other GI problems?		
Ever had an eating disorder?		
Have a special diet or need to avoid certain foods?		
Are there any concerns about your child's weight?		
INJURY HISTORY	NO	YES
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?		
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?		
Have a bone, muscle, or joint that bothers them?		
Have joints that become painful, swollen, warm, or red with use?		
Ever been diagnosed with a stress fracture?		

Athlete's Name:		DOB:	
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DOES OR HAS YOUR CHILD		
HEART HEALTH		
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?		
Lightheadedness, dizziness, during or after exercise?		
Chest pain, tightness, or pressure during or after exercise?		
Fluttering in the chest, skipped heartbeats, heart racing?		
DOES OR HAS YOUR CHILD		
Ever been told by a health care provider		
They have or had a heart or blood vessel problem?		
If yes, check all that apply:		
<input type="checkbox"/> Chest Tightness or Pain <input type="checkbox"/> Heart infection <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> New fast or slow heart rate <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Has implanted cardiac defibrillator (ICD) <input type="checkbox"/> Has a pacemaker <input type="checkbox"/> Other:		

DOES OR HAS YOUR CHILD		
FEMALES ONLY	No	Yes
Have regular periods?		
MALES ONLY	No	Yes
Have only one testicle?		
Have groin pain or a bulge, or a hernia?		
SKIN HEALTH	No	Yes
Currently have any rashes, pressure sores, or other skin problems?		
Ever had a herpes or MRSA skin infection?		
COVID-19 INFORMATION		
Has your child ever tested positive for COVID-19?		
If <b>NO, STOP.</b> Go to Family Heart Health History. If <b>YES,</b> answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?		
Did your child see a health care provider for their COVID-19 symptoms?		
Was your child hospitalized for COVID?		
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?		

FAMILY HEART HEALTH HISTORY	
A relative has/had any of the following:	
Check all that apply:	
<input type="checkbox"/> Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy <input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy? <input type="checkbox"/> Heart rhythm problems: long or short QT interval?	<input type="checkbox"/> Brugada Syndrome? <input type="checkbox"/> Catecholaminergic Ventricular Tachycardia? <input type="checkbox"/> Marfan Syndrome (aortic rupture)? <input type="checkbox"/> Heart attack at age 50 or younger? <input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)?
A family history of:	
<input type="checkbox"/> Known heart abnormalities or sudden death before age 50? <input type="checkbox"/> Structural heart abnormality, repaired or unrepaired? <input type="checkbox"/> Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?	

If you answered <b>NO</b> to <u>all</u> questions, <b>STOP.</b> Sign and date below. <b>GO</b> to page 3 if you answered <b>YES</b> to a question.	
Parent/Guardian Signature:	Date:

