Heart for Athletes Heart Health Survey

Please complete the following questions regarding the individual being screened:

DEMOGRAPHICS

Age: _____ Grade: ____ Height: ___ft ___in Weight: ____lb

Gender: ___ Male ___ Female BP: ______ / ______ *

(*BP filled in at screening)

Race/ethnicity: (check all that apply)
__ African-American/Black
__ Caucasian/White
__ Hispanic/Latino
__ Asian/Pacific Islander
__ Native American
__ Other: please specify: _____________________________________________

SPORTS & PHYSICAL ACTIVITY

1) Do you play on an organized team or compete in an individual sport? __ Yes __ No

If yes, what level: __ Club/Select __ Recreational/Intramural __ High School

If yes, what sport(s) do you play competitively or on an organized team?
(check all that apply)
__ Baseball __ Golf __ Skiing
__ Basketball __ Gymnastics __ Squash
__ Cheer __ Hockey __ Swimming/Diving
__ Cross Country __ Lacrosse __ Tennis
__ Cycling __ Martial Arts __ Track
__ Football __ Rowing __ Volleyball
__ Field hockey __ Rugby __ Wrestling
__ Fencing __ Soccer __ Other: ________
__ Frisbee __ Softball

2) Exercise and physical activity per week. On average I get… (check one)

__ More than 10 hours of exercise or physical activity per week
__ 5-10 hours of exercise or physical activity per week
__ 2-5 hours of exercise or physical activity per week
__ Less than 2 hours of exercise or physical activity per week
PAST MEDICAL HISTORY

Do you have any ongoing medical illnesses? ___ Yes ___ No
If yes, what illness? ___ asthma ___ ADHD ___ diabetes ___ high blood pressure
___ pre-existing heart condition _____________________
___ other: _________________________________________

Are you taking any medication(s)? ___ Yes ___ No If yes, what medication(s)?
________________________________________________________________

Have you had a sports physical examination by a physician or other medical provider within the last 12 months? ___ Yes ___ No

Has a doctor ever ordered a test for your heart? (i.e., EKG or echo)? ___ Yes ___ No

HEART HEALTH QUESTIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1. Do you get chest pain when you exercise?</td>
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<td>2. Have you ever passed out during or immediately after exercise?</td>
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<td>3. Do you have unexplained shortness of breath or fatigue during exercise?</td>
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<td>4. Does your heart ever suddenly race (beat fast) not related to exercise?</td>
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<td>5. Have you ever had an unexplained seizure?</td>
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<td>6. Have you ever been diagnosed with: (if yes, check all that apply)</td>
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<td>___ high blood pressure</td>
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<td>___ high cholesterol</td>
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<td>___ Kawasaki disease</td>
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<td>___ a heart infection</td>
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<tr>
<td>___ another heart problem</td>
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<td>7. Has anyone in your family died suddenly from a heart problem before the age of 50?</td>
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<td>8. Has anyone in your family died suddenly for an unknown reason before the age of 50 (including sudden infant death syndrome (SIDS), unexplained car accident, or drowning)?</td>
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<td>9. Does anyone in your family have any of the following specific genetic heart conditions:</td>
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<td>___ hypertrophic cardiomyopathy, ___ dilated cardiomyopathy, ___ arrhythmogenic right ventricular cardiomyopathy (ARVC), ___ long QT syndrome, ___ short QT syndrome, ___ catecholaminergic polymorphic ventricular tachycardia (CPVT), ___ Brugada syndrome, or ___ Marfan syndrome. (check if any apply)</td>
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</table>
Heart for Athletes Heart Screening
AGREEMENT TO PARTICIPATE IN HEART SCREENING

CONTACT INFORMATION

Student Name:__________________________________________________     DOB: ___ / ___ / _____

Street Address:_______________________________________________________________________

City:________________________________ State:_________   Zip:______________

Home Phone:_______________________   Mobile Phone:________________________

Parent/Guardian Name:____________________________________________________

Parent/Guardian Email:____________________________________________________

Heart for Athletes is offering a free heart screening to teenagers to identify selected heart abnormalities in
an effort to minimize the risk of sudden cardiac death. Many abnormalities of the heart can potentially
cause sudden cardiac death and some of them can be detected by using electrocardiogram and/or
echocardiogram. However, these screenings do not always detect cardiovascular abnormalities when
present, and not all potentially fatal heart abnormalities can be detected by this screening.

The Heart for Athletes Heart Screening will include a measure of blood pressure, a modified Electrocar-
diogram (measures the electrical activity in the heart), and a limited Echocardiogram (2-dimensional
ECHO or ultrasound picture of the heart). Medical personnel will provide an assessment of the data
(normal or abnormal) on the day of the screening. All data collected related to the heart screen will be
reviewed by a board certified pediatric cardiologist to ensure accuracy. Any teenager having an abnormal
screen will be offered the opportunity to undergo a more thorough evaluation so that a plan for care can
be established. The identity of the screening participant and information obtained in the screening
program will remain confidential and available only to Heart for Athletes and the physicians directly
working with Heart for Athletes.

Data Collection, Analysis and Reporting:

The data collected related to your heart screen will be reviewed by medical personnel participating in our
event and may be used in an aggregate form (no names or identifiers) as part of a research study on
heart screening in the young. In agreeing to your heart screen, you understand and provide permission
that the information collected about you during the screening process, including the information contained
in your medical Heart Health Survey (pages 1 and 2 of this form), will be reviewed by medical personnel
and can be included in a research study. Medical personnel will provide you with a summary of the
results of your screening and may recommend additional evaluation through follow-up with your physician
or specialist.

By agreeing to participate in the program, if so indicated you give permission to Heart for Athletes and
medical personnel to provide your screening results to your physician(s), and you authorize your
physicians to share the results and diagnosis of any subsequent testing with Heart for Athletes.

I hereby give my permission for images of my child and/or myself, captured during a youth heart
screening through video, photo or digital camera, to be used solely for the purposes of Heart for Athletes
promotional material and publications, and waive any rights of compensation or ownership thereto.

HFA Heart Health Survey 9.2018
Participant Consent:

I acknowledge that I have read the above agreement to participate and understand its contents. Any questions have been answered to my satisfaction. I agree to be a participant in this heart screening, and in connection therewith, I consent to the release of information obtained in connection with the screening as described above to my primary care physician and cardiologist. I understand that Heart for Athletes will not disclose my identity to any third party without my consent. I understand that I may withdraw from the screening. I understand that no warranty or guarantee has been made to me as to the results or accuracy of the EKG screening and ECHO procedure. I understand that this screening may not be sufficient for diagnosis purposes and that an additional procedure(s) might be required in the event of an abnormal finding on the EKG screening and/or ECHO procedure. I also understand that upon further evaluation, a suspected abnormal finding on the initial screening may or may not confirm that there is truly an abnormality present. I further agree to hold Heart for Athletes, all physicians, technicians, volunteers, and all other persons, entities, individuals and organizations harmless and waive all subrogation rights against Heart for Athletes and their directors, trustees, officers and volunteers.

Date: ________________________________  Signature of Participant

Parental/Guardian Consent for Participants under the Age of 19:

As parent/guardian of the above minor participant, I acknowledge that I have read the above agreement to participate and understand its contents. Any questions have been answered to my satisfaction. I grant permission for my child to participate in this cardiovascular screening. I consent to the release of information in connection with the screening as described above, if abnormal cardiac screening results are found, to his/her primary care physician and/or a pediatric cardiologist. I understand Heart for Athletes will not disclose my child’s identity to any third party without my consent. I understand that I may withdraw my child from the screening or follow-up at any time without penalty.

Date: ________________________________  Signature of Parent/Guardian

(printed name of primary care physician)             (printed name of cardiologist) *

* If follow-up with a cardiologist is necessary, names of local pediatric cardiologists will be provided during the consultation at the screening event. You do not need to provide this info at check-in.
ID #: __________________________

DISCLAIMER AND WAIVER OF MEDICAL LIABILITY

I understand, acknowledge, and agree that Heart for Athletes, Inc., an Alabama non-profit corporation (the “Testing Company”), is not a medical practice or firm and does not employ, or hire as consultants or contractors, any physicians or doctors or any person otherwise licensed to practice medicine in the State of Alabama or in any other State. Any and all physicians or licensed medical professionals who may review or evaluate the results of any testing performed on your child are doing so solely on a voluntary basis directly on my and my child’s behalf and have no contractual, legal, fiduciary or other form of formal relationship with the Testing Company, and are not receiving any direct form of compensation, remuneration, or payment from the Testing Company for performing such services. Therefore I understand, acknowledge, and agree that the Testing Company (A) does not give or make, nor can it give or make, any medical advice or recommendations, or prescribe any course of treatment, and expressly disclaims any and all such advice, and (B) does not have any control over the review by any physician, doctor, or other licensed medical professional of the results of any testing conducted on my child by the Testing Company, or the results of any such review and communication of such results to myself and/or my child.

THEREFORE, I UNDERSTAND, ACKNOWLEDGE AND AGREE THAT THE TESTING COMPANY DOES NOT ASSUME, AND IS NOT RESPONSIBLE FOR PROVIDING, MY CHILD WITH ANY MEDICAL OR SIMILAR PROFESSIONAL STANDARD OF CARE, OR DUTY OR RESPONSIBILITY, WITH RESPECT TO THE PERFORMANCE OF ANY TESTING, AND DOES NOT ASSUME ANY DUTY TO PROVIDE, AND WILL NOT PROVIDE, ANY MEDICAL CARE OR ADVICE. I FURTHER UNDERSTAND, ACKNOWLEDGE AND AGREE THAT THE TESTING COMPANY IS NOT RESPONSIBLE OR LIABLE FOR, AND EXPRESSLY DISCLAIMS, ANY AND ALL ADVICE, RECOMMENDATIONS, OR COURSES OF TREATMENT WHICH ARE PROVIDED BY ANY PHYSICIAN WHICH REVIEWS AND/OR EVALUATES THE RESULTS OF ANY TESTING. I FURTHER UNDERSTAND, ACKNOWLEDGE AND AGREE THAT THE TESTING COMPANY IS NOT RESPONSIBLE OR LIABLE FOR, AND EXPRESSLY DISCLAIMS, THE OUTCOME AND/OR PERFORMANCE OF ANY REVIEW AND/OR EVALUATION, AND ANY CONCLUSION OR RECOMMENDATION, BY ANY PHYSICIAN, DOCTOR, OR OTHER LICENSED MEDICAL PROFESSIONAL BASED ON OR IN CONNECTION WITH THE RESULTS OF ANY TESTING CONDUCTED ON MY CHILD BY THE TESTING COMPANY, INCLUDING BUT NOT LIMITED TO ANY NEGLIGENCE OR MEDICAL MALPRACTICE ON THE PART OF SUCH PHYSICIAN, DOCTOR, OR OTHER LICENSED MEDICAL PROFESSIONAL.

As such, I, on behalf of myself and my child, and our assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives (the “Releasing Parties”), do hereby absolutely, fully, and forever release, relieve, waive, relinquish and discharge the Testing Company (as identified above) and any and all of the Testing Company’s directors, officers, volunteers, agents, contractors, and representatives (the “Released Parties”), of and from any and all actions or causes of action, actual or alleged claims, of any kind or undiscovered, accrued or un-accrued, suspected or unsuspected, which any Releasing Party may now have claim to have, or which may at any time hereafter accrue, arising out of, in connection with, in consequence of, in any way involving, or related to the review, evaluation, interpretation and communication of the results of any of the tests or testing as described in this document by any physician, doctor, or other medical professional (the “Reviewing Physician”), including but not limited to any failure to detect any heart condition which results in personal injury to or the death of my child, whether due to the negligence or medical malpractice by such Reviewing Physician or otherwise.

Signature of Parent/Guardian/Legal Custodian: Acknowledged and agreed, on behalf of and in connection with the testing to be performed by the Testing Company on __________________________.  
(print name of child)

Parent’s Signature:________________________________ Date:________________________

HFA Heart Health Survey 9.2018
Thank you for allowing the Cardiac and Vascular Institute of Ultrasound (CVIU) students to perform an ultrasound exam on you; we greatly appreciate you volunteering your time. The primary purpose of this exam is to benefit the training of CVIU students.

In no way are we claiming or in any way suggesting to you that the examination performed by the student will be read/interpreted by a Cardiologist, Vascular Surgeon, or other physician. If you believe you have symptoms of any cardiovascular disorder or pathology you should contact your family physician, a cardiologist, vascular surgeon, or other physician to examine you.

The student will send a report of their findings to the requesting institute or physician. Otherwise, you will not be contacted or receive any information from CVIU.

If you were not referred by an institution or physician and the student observes any significant signs of pathology or disorders he/she will inform you. It is your responsibility to immediately contact your family physician, a cardiologist, vascular surgeon, or other physician to be examined.

IN NO WAY IS CVIU CLAIMING YOUR EXAMINATION TO BE AN ACCURATE DIAGNOSTIC STUDY OF YOUR CARDIOVASCULAR SYSTEM OR PERSONAL HEALTH.

I, ______________________________, have read the above statement and fully understand that the ultrasound exam performed by the students at CVIU is NOT to be considered as accurate or fully disclosing any disorders, diseases, and/or sicknesses I may possess.

Contact Information for Volunteer:

Address: ____________________________________________

____________________________________________________

Home Phone: ___________________ Cell Phone: ______________

Email Address: ________________________________

Signature of Volunteer: ___________________________ Date: _____________