

**STUDENT HEART SCREENING
CONSENT FORM**

Student's Name: _____ Date of Birth: _____

Students participating in the Heart Screening Program will have their height, weight and blood pressure measured. They will also have an EKG and a brief, limited echocardiogram. These tests will be focused on detection of specific heart abnormalities, including hypertrophic cardiomyopathy (an abnormal thickening of the heart muscle), an abnormal enlargement of the aorta (the main blood vessel that leaves the heart), certain heart valve abnormalities, and abnormal electrical conduction in the heart. These abnormalities may be missed on a routine physical examination. Participation in this screening program is completely voluntary. Students may also be offered an optional non-fasting total cholesterol test that involves pricking the finger to obtain the blood sample.

1. I and my child hereby give consent for my child to participate in the Heart Screening Program.
2. I and my child understand that my child's primary physician, as identified on the student information form, will be informed of the results of the screening tests.
3. I and my child understand that the screening test is not a substitute for a complete cardiac evaluation or a sports pre-participation physical.
4. I and my child understand that the screening test will not identify all possible heart abnormalities.
5. I and my child understand that some heart abnormalities are progressive over time; therefore, a "normal" heart screening now does not guarantee that there will be no abnormalities in the future.
6. I and my child understand that if certain heart abnormalities are identified, restriction from competitive sports may be recommended for my child.
7. I and my child understand that if the screening test is not normal, it will be my responsibility to discuss the results with my child's physician and to follow any recommendations for further testing or treatment.
8. I and my child understand that the non-invasive screening test requires the use of a lubricant that may cause a minor, temporary skin irritation in persons with hypersensitivity.
9. I and my child agree to release the Heart Institute of the Cascades, St. Charles Medical Center, Pediatric Heart Center of Central Oregon, Heart Center Cardiology, their employees, and all other organizations involved in the Heart Screening Program from any liability or responsibility from damages arising out of or in connection with my child's participation in this program.

Please check one box:

Yes – Perform the optional cholesterol screening – draw blood by pricking my son's/daughter's finger.

No – Do not perform the optional cholesterol screening – do not draw any blood from my son/daughter.

Name of Student (please print): _____

Student's signature: _____ Date: _____

Name of Parent/Guardian (please print): _____

Parent/Guardian's signature: _____ Date: _____

STUDENT INFORMATION FORM

Student's Name: _____

Date of Birth: _____ **Age:** _____ **Male** **Female**

Parent(s)/Guardian(s) living with student: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone Number: _____ **Email:** _____

Student's Physician: _____

Physician's Address: _____

City: _____ **State:** _____ **Zip:** _____

Which sport(s) does the student regularly participate in?

Is there any known history of heart problems in the student? **Yes** **No**

Is there any family history of:
People born with heart defects **Yes** **No**

People with heart rhythm abnormalities detected at a young age **Yes** **No**

People who died suddenly at a young age **Yes** **No**

Please explain any "Yes" responses:

