



ID NUMBER _____

COMMUNITY HEART SCREENING

AGREEMENT TO PARTICIPATE IN HEART SCREENING

Heart Screen New York is offering a heart screening program for students, athletes, and young adults age 14-25. The information obtained from participants will be reviewed by medical personnel at the event. The identity of the screening participants and information obtained in the screening program will remain confidential and available only to Heart Screen New York and the physicians helping at the event. The screening program may include:

1. Medical History Questionnaire
2. Blood pressure
3. Physical examination
4. Electrocardiogram (ECG- measures electrical activity in the heart)
5. Echocardiogram (Echo- an ultrasound picture of the heart)

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, 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 Screen New York and medical personnel to provide your screening results to your physician, cardiologist, and enrolled school. You authorize your physician to share the results and diagnosis of any subsequent testing with Heart Screen New York.

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 Screen New York promotional material and publications, and waive any rights of compensation or ownership thereto.

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. I understand that Heart Screen New York will not disclose my identity to any third party without my consent. I understand that I may withdraw from the screening. I further agree to hold Heart Screen New York, all physicians, technicians, volunteers, and all other persons, entities, individuals and organizations harmless and waive all subrogation rights against Heart Screen New York and their directors, officers and volunteers as respects process and results of this free heart screening performed on this day.

Date: _____

Signature of Participant

Parental/Guardian Consent for Participants under the Age of 18:

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. I understand Heart Screen New York 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



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HEART HEALTH SURVEY

CONTACT INFORMATION

Student Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____

Home Phone: _____ Mobile Phone: _____

Parent/ Guardian Name: _____

Parent/ Guardian Email Address: _____

Heart Screen New York is providing this Heart Screening at no cost or obligation.

However, to help defer screening costs, and enable future community screening events, there is a suggested donation of \$25.00.

Donations are tax deductible, and can be made by cash or check payable to:

Louis J. Acompora Memorial Foundation

Or by online donation at: www.la12.org

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Please complete the following questions regarding the individual being screened:

DEMOGRAPHICS

Age: _____

Gender: Male Female

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 sports team or compete in an individual sport? Yes No

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

If yes, what sport(s) do you play? (check all that apply)

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Golf | <input type="checkbox"/> Skiing |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Squash |
| <input type="checkbox"/> Cheer | <input type="checkbox"/> Hockey | <input type="checkbox"/> Swimming/Diving |
| <input type="checkbox"/> Cross country | <input type="checkbox"/> Lacrosse | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Cycling | <input type="checkbox"/> Martial arts | <input type="checkbox"/> Track |
| <input type="checkbox"/> Football | <input type="checkbox"/> Rowing | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Field hockey | <input type="checkbox"/> Rugby | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Fencing | <input type="checkbox"/> Soccer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Frisbee | <input type="checkbox"/> 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



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PAST MEDICAL HISTORY

Do you have any ongoing medical illnesses? Yes No

If yes, what illness? Asthma ADHD Diabetes High blood pressure

Other: _____

Are you taking any medication? Yes No

If yes, what medication? _____

HEART HEALTH QUESTIONS	Yes	No
1. Do you get chest pain when you exercise?		
2. Have you ever passed out during or immediately after exercise?		
3. Do you have difficulty breathing or unexplained fatigue during exercise that is new or getting worse?		
4. Does your heart ever race (suddenly beat fast) without good reason?		
5. Have you ever had a seizure?		
6. Have you ever been diagnosed with: (if yes, check all that apply) <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart infection <input type="checkbox"/> High cholesterol <input type="checkbox"/> Another heart problem <input type="checkbox"/> Kawasaki disease		
7. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, or echocardiogram)		
8. Has anyone in your family died from a heart problem before the age of 50?		
9. 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)?		
10. Does anyone in your family have any of the following medical problems: 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 (if yes, please circle)		