

For internal use only:

HT: _____
WT: _____
BP: _____
RR: _____
HR: _____



HEALTH & FAMILY HISTORY (RELEASE & WAIVER)

Chart# _____		Participant Information								
Name				DOB / /		Age	Gender			
Address						Apt/Suite #				
City				State		Zip				
Height	Weight	Ethnicity - Check ALL that apply →			<input type="checkbox"/> Black	<input type="checkbox"/> Hispanic	<input type="checkbox"/> White	<input type="checkbox"/> Asian	<input type="checkbox"/> Indian	<input type="checkbox"/> Other
Parent/Legal Guardian Information										
Name				Home #			Cell #			
Address						Apt/Suite #				
City				State			Zip			
Email										

Check Sport(s) Participation:

- Band
- Cross Country
- Gymnastics
- Softball
- Track & Field
- Baseball
- Dance
- Golf
- Swimming
- Volleyball
- Basketball
- Diving
- Lacrosse
- Tennis
- Wrestling
- Cheerleading
- Football
- Soccer
- Other _____

DO YOU WANT A COPY OF THE RESULTS TO BE SENT TO YOUR PHYSICIAN? Yes No

Physician Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Please indicate how you would prefer to receive these results:

Email address: _____

Mail address: _____ City: _____ State: _____ Zip: _____

Disclosure

Kansas City Pediatric Cardiology Associates, LLC. (KCPCA), offers heart screenings to youth (ages 10-25) in an effort to help diagnose heart abnormalities. Many abnormalities of the heart can potentially cause Sudden Cardiac Death. Hypertrophic Cardiomyopathy ("HCM") is probably the most common cause and may often be detected by an echocardiogram (2-D echo) or an electrocardiogram ("EKG"). Other significant heart abnormalities may also be detected using 2-D echo and EKG. However, screening does not always detect an abnormality even when it is actually present and not all potentially fatal heart abnormalities can be detected by this screening.

This form is intended to inform you about the screening, and document your consent. It is important you take personal responsibility for your health needs (or those of your child) and we ask for your personal commitment to obtain appropriate follow-up care and treatment in the event the screening detects any important heart abnormality.

Personal Commitment to Follow-up Results

I recognize and acknowledge that I am personally responsible for taking appropriate follow-up action upon receipt of test results. I understand and acknowledge that it is my responsibility to decide whether to take this action and pursue medically indicated care and treatment. I understand that follow-up care and treatment is not a part of this program and that I am financially responsible for the cost of any and all follow-up care, treatment and/or procedures whether or not covered by my insurance.

*****ATTENTION PARENTS *** PLEASE VERIFY ALL QUESTIONS ARE ANSWERED COMPLETELY!**

PHYSICAL ACTIVITY - (Student/Athlete)		v	
1	How much exercise / physical activity per week? <div style="text-align: right;"> More than 10 hours per week <input type="checkbox"/> 5 to 10 hours per week <input type="checkbox"/> 2 to 5 hours per week <input type="checkbox"/> Less than 2 hours per week <input type="checkbox"/> </div>		
PAST MEDICAL HISTORY – (Student/Athlete)			
2	Do you have any ongoing medical illness? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, what illness? <input type="checkbox"/> Asthma <input type="checkbox"/> ADHD <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Pre-existing heart Condition <input type="checkbox"/> Other: _____		
3	Are you taking medication(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, what medication(s)? _____		
4	Have you had a sports physical exam by a medical provider within the last 12 months? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
HEART HEALTH QUESITONS – (Student/Athlete)		Yes	No
5	Do you have chest pain or pressure when exercising?	<input type="checkbox"/>	<input type="checkbox"/>
6	Have you ever passed out during exercise or immediately after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7	Do you have <u>unexplained</u> shortness of breath or fatigue during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8	Does your heart ever <u>suddenly</u> race (beat fast) without good reason?	<input type="checkbox"/>	<input type="checkbox"/>
9	Have you ever had an unexplained seizure?	<input type="checkbox"/>	<input type="checkbox"/>
10	Have you been diagnosed with : (if yes, check all that apply) <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Heart infection <input type="checkbox"/> Heart problem(s)		
11	Has anyone in your family <u>died suddenly</u> from a heart related condition before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>
12	Has anyone in your family <u>died suddenly</u> for an unknown reason before the age of 50 (including sudden infant death syndrome (SIDS), unexplained car accident, or drowning)?	<input type="checkbox"/>	<input type="checkbox"/>
13	Does anyone in your family have any of the following <u>specific genetic conditions</u> : <input type="checkbox"/> Hypertrophic Cardiomyopathy <input type="checkbox"/> Dilated Cardiomyopathy <input type="checkbox"/> Marfan Syndrome <input type="checkbox"/> Brugada Syndrome <input type="checkbox"/> Long QT syndrome <input type="checkbox"/> Short QT syndrome <input type="checkbox"/> Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) <input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)		

Communication of Results

A copy of the results will be made available via mail or electronic methods no less than 10 days after completion of the screening. Should the results show a potential abnormality, you will be given instructions to seek a comprehensive evaluation by your personal physician.

Please carefully read and acknowledge your understanding of the following important information relating to your legal rights under this screening program.

Consent to Screening

I do hereby grant permission for my child/ward to participate in the voluntary echocardiogram and electrocardiogram ("ECG") screening in which he/she will receive a cardiac screening. This screening will seek to detect certain heart abnormalities. Risks for the screening test include the possibility of minor skin irritation and redness where the electrodes were placed.

I understand that this is a voluntary screening and should not be construed as a complete cardiac evaluation, especially relating to valve abnormalities which may not be completely evaluated. I further understand that KCPCA is not responsible for further screening, medical evaluation, medical care or treatment of my child/ward. Any further medical follow-up is solely my responsibility.

I voluntarily request KCPCA and its employed and contracted associates, technologists, technical assistants, cardiologists and other health care providers to administer, interpret and communicate the results of the screening. I understand that these procedures involve the use of cardiac imaging and electrical detection technology. I have truthfully completed a medical health history questionnaire. I understand that a screening echocardiogram and ECG may not be sufficient for diagnosis purposes and may not detect an abnormality even when it is actually present. I understand that an additional procedure(s) might be required in the event that an abnormal finding is made. Completed evaluations upon a suspected abnormal finding on the initial screening may or may not confirm that there is truly an abnormality present. I have been given an opportunity to ask questions about the risks of non-detection, the nature, purpose, and anticipated benefits of the screening to be used, and the risks and hazards involved. I believe that I have sufficient information to give and do hereby freely give my permission for my child to be screened.

No Warranty or Guarantee

I understand that no warranty or guarantee has been made to me as to the results of the screening echocardiogram and electrocardiogram procedure. I understand that this test screens for mainly one of several causes of sudden cardiac death. A normal screening study does not rule out all heart causes of sudden death.

Release of Claims; Indemnity

I, on behalf of myself, my child/ward, and our respective representatives, executors and administrators, do hereby absolutely, fully and forever release, relieve, waive, relinquish and discharge KCPCA, and any hospital, physician and their respective agents, servants, employees, representatives, trustees, administrators, successors, partners, principals, officers, directors, shareholders, parents, subsidiaries and affiliates and each of them involved in this screening event (collectively referred to as the "Released Parties"), of and from any and all actions or causes of action, actual or alleged claims, judgments, demands, debts, losses, obligations, liabilities, costs, expenses, sums of money, damages and/or liens of any kind, known or unknown, discovered or undiscovered, accrued or un-accrued, suspected or unsuspected, on account of any injury to my child/ward, or to any person or property, whether or not resulting in death, and whether or not caused by the negligence of the Released Parties, collectively or individually, by third parties, or otherwise, and including any claims which may involve or are otherwise related to the performance, interpretation and communication of the results of the screening echocardiogram and/or electrocardiogram (collectively, "Claims"). I further hereby covenant and agree to defend, indemnify and hold harmless the Released Parties from and against any and all Claims made by, on behalf of, or for my child/ward or any person who may have a Claim by, through or with respect to my child/ward.

Waiver

I understand and agree that the Release set forth above is intended to be a full general release of all claims of every kind whatsoever, known or unknown, discovered or undiscovered, suspected or unsuspected, arising out of, in connection with, in consequence of, in any way involving, or related to the performance, interpretation and communication of results of the screening Echocardiogram and Electrocardiogram. I understand and acknowledge that I am expressly waiving my rights under state and federal laws to the full extent that I may lawfully waive all such rights and benefits pertaining to the subject matter hereof.

Acknowledgement

THE UNDERSIGNED PARTICIPANT AND PARENT AND/OR GUARDIAN HEREBY CERTIFY THAT PARTICIPANT IS UNDER 18 YEARS OLD, THAT I HAVE COMPLETELY READ AND UNDERSTAND THIS AGREEMENT AND ITS TERMS, AND THAT PRIOR TO SIGNING THIS RELEASE, I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS ABOUT THIS RELEASE. THE UNDERSIGNED FURTHER CERTIFIES THAT I/WE AM/ARE A PARENT/GUARDIAN OF THE PARTICIPANT, AND I/WE ATTEST THAT I/WE HAVE LEGAL RESPONSIBILITY OVER THE PARTICIPANT, AND, MY/OUR SIGNATURE IS SUFFICIENT TO CONSENT TO THE PARTICIPATION OF THE PARTICIPANT IN THE ACTIVITIES AND TO ENTER INTO THIS AGREEMENT FOR AND ON BEHALF OF THE PARTICIPANT.

_____	_____	_____
Participant Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date