(888) 862-8518

HEALTH & FAMILY HISTORY (RELEASE & WAIVER)

This line for ATS use only:	Weight (lbs)	Height (inches)	BP /

Participant Information							
Name				DOB / /		Age	Gender on Birth Cert.
Ethnicity - Check ALL that apply →	Black	Hispanic	White	Asian	American Indian	Other	

Parent Information		
Parent / Legal Guardian Name	Mobile #	Other #
Address		Apt/Suite #
City	State	Zip
Email		

Check Sport('s) Participation:

O Baseball	O Football	O Lacrosse	O Soccer	O Tennis
O Basketball	O Field Hockey	O Softball	O Rugby	O Track
O Cheer/Dance	O Golf	O Martial Arts	O Ski/Snow Brd.	O Volleyball
O Cross Country	O Gymnastics	O Rowing	O Swim/Dive	O Wrestling
O Cycling	O Hockey	O Rock Climbing	O Other _____	

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

Physician Name: _____

Address: _____

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

Physician's Telephone Number: _____

Physician's Fax Number: _____

Disclosure

Athletic Testing Solutions ("ATS") offers heart screenings to youth (ages 8-25) in an effort to help diagnose congenital and genetic heart abnormalities. Many abnormalities of the heart can potentially cause Sudden Cardiac Arrest. Most abnormalities may be detected by an echocardiogram (2-D echo) or an electrocardiogram ("EKG"), both which are included in the ATS screening. 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 advise you about the screening, and document your consent. It is essential you take personal responsibility for your health needs (or those of your child) and we request your personal commitment to obtain appropriate follow-up care and treatment in the event the screening detects any important heart abnormality. It is solely your responsibility to notify any organization director, school district official, athletic director, or coach if it is recommended you be restricted from physical activity, even if temporary, by the medical professionals from ATS.

Communication of Results

A copy of the results will be made available via email 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.

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

PHYSICAL ACTIVITY - (Student/Athlete)		**√**
1 How much exercise / physical activity per week?	More than 10 hours per week	
	5 to 10 hours per week	
	2 to 5 hours per week	
	Less than 2 hours per week	

PAST MEDICAL HISTORY – (Student/Athlete)

2 Do you have any ongoing medical illness? ☐ YES ☐ NO

If Yes, what illness? ☐ Asthma ☐ ADHD ☐ Diabetes ☐ High Blood Pressure

☐ Pre-existing heart Condition ☐ Other: _____

3 Are you taking medication(s)? ☐ YES ☐ NO

If Yes, what medication(s)? _____

4 Have you had a sports physical exam by a medical provider within the last 12 months? ☐ YES ☐ NO

HEART HEALTH QUESITONS – (Student/Athlete	**Yes**	**No**
5 Do you have chest pain or discomfort when exercising?		
6 Have you ever passed out or nearly passed out during exercise or immediately after exercise?		
7 Do you have <u>unexplained</u> shortness of breath or fatigue during exercise?		
8 Does your heart ever <u>suddenly</u> race (beat fast) without good reason?		
9 Have you ever had an unexplained seizure?		

10 Have you been diagnosed with: (check all that apply)

☐ High blood pressure ☐ High cholesterol ☐ Heart murmur

☐ Heart infection ☐ Heart problem(s) ☐ Kawasaki disease

11	Has anyone in your family <u>unexpectedly died suddenly</u> from a **heart related condition** <u>before the age of 50</u>?		
12	Has anyone in your family <u>died suddenly</u> for an **unknown reason** <u>before the age of 50</u> (including sudden infant death syndrome (SIDS), unexplained car accident, or drowning)?		

13 Does anyone in your family have any of the following <u>specific genetic conditions</u>:

☐ Hypertrophic Cardiomyopathy ☐ Dilated Cardiomyopathy ☐Marfan Syndrome

☐ Brugada Syndrome ☐ Long QT syndrome ☐ Short QT syndrome

☐ Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) ☐ Wolff-Parkinson-White Syndrome

☐ Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)

For ATS Use Only:

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 in certain conditions which may not allow for complete evaluation. I further understand that ATS is not responsible for further screening, medical evaluation, medical care, or treatment of my child/ward.

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.

I voluntarily request ATS 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.

_____ **(please initial)** I further authorize ATS to photograph or permit other persons to photograph, record, conduct media interviews and/or publish information or images obtained while participating in the screening event. I agree that the photographs and/or radio or television broadcast tape may be used in publication or in broadcast format with radio or television, or websites. I agree that ATS may use and permit other persons to use the negatives or prints prepared from such photographs for such purposes and in such manner as either may deem appropriate. I understand and agree that the photographs, recording and/or publication may reveal the patient's identity. I agree that the photographs may be used for any purposes including, but not limited to dissemination to hospital staff, physicians, health professionals and members of the public for education, treatment, research, scientific, public relations, promotional and charitable purposes and that such dissemination may be accomplished in any manner and hereby waive any rights to compensation for such uses by reason of the foregoing authorization.

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. 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 ATS, and any hospital, physician and their respective agents, 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