



Louisiana Pediatric
Cardiology Foundation

Student Athlete Heart Screen Consent Forms

Part 1. Student Information (To be completed by student or parent. Please print clearly!)

Student's Name (First & Last): _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____ (cell) _____

Email Address : _____

Gender (circle one): Male Female Age: _____ Grade _____

School: _____

Sport(s): _____

Height: _____ Weight: _____

Have you had a heart screen from LPCF before? YES NO If Yes, when? _____

In case of emergency, contact:

Name of Parent/Guardian: _____

Relationship to Student: _____ Phone: _____

Part 2. Informed Consent (to be signed by student and parent)

Louisiana Pediatric Cardiology Foundation (LPCF), in partnership with Pediatric Cardiology Associates (PCA), offers **FREE** heart screens as our commitment to serving the preventive health needs of our community. This consent form is meant to inform the screening participant about the screening and to document the participant's consent to the screening. The form is meant to inform the participant of the importance of taking personal responsibility for healthcare needs and asks for a personal commitment from the participant to obtain appropriate follow-up care and treatment in the event the

screening is abnormal. In order to participate and be screened through LPCF's "Save-A-Heart" Screening Program, every participant must read and sign this Notice, Informed Consent and Release.

ABOUT THE SCREENING: LPCF screens young adults for a genetic heart condition called Hypertrophic Cardiomyopathy (HCM). This condition, which causes a thickening of the heart wall, typically does not present any symptoms and can lead to the obstruction of blood flow and an erratic heartbeat. It is the leading cause of sudden cardiac death in young people.

Sudden cardiac death (also called sudden arrest) is death resulting from an abrupt loss of heart function (cardiac arrest). The victim may or may not have diagnosed heart disease. The time and mode of death are unexpected. It occurs within minutes after symptoms appear. When sudden death occurs in young adults, other heart abnormalities are more likely causes. Adrenaline release during intense physical or athletic activity often acts as a trigger for sudden death when these abnormalities are present.

An echocardiogram, also referred to as an "ECHO", is a technique that sends sound waves (like sonar) into the chest to rebound from the heart's walls and valves. The recorded waves show the shape, texture, and movement of the valves on an echocardiogram. They also show the size of the heart chambers and how well they are working.

An electrocardiogram, also called an "EKG", is a test that measures the electrical activity of the heartbeat. With each beat, an electrical impulse (or "wave") travels through the heart. This wave causes the muscle to squeeze and pump blood from the heart. An EKG gives two major kinds of information. First, by measuring time intervals on the EKG, a doctor can determine how long the electrical wave takes to pass through the heart. Finding out how long a wave takes to travel from one part of the heart to the next shows if the electrical activity is normal or slow, fast or irregular. Second, by measuring the amount of electrical activity passing through the heart muscle, a cardiologist may be able to find out if the parts of the heart are too large or are overworked.

RISKS: This screening does not hurt and is non-invasive. No needles or sedation is used. However, should the participant experience chest pain, difficulty breathing, discomfort radiating into the neck or arm, or discomfort combined with lightheadedness, sweating, fainting or nausea, the participant should seek prompt medical attention.

PARTICIPATION: By voluntarily participating in this screen program and by receiving a screening I recognize, understand, and accept all risks and responsibilities associated with and resulting from it. This screening program will only screen for abnormalities in the heart using the electrocardiogram and echocardiogram, and does not constitute a complete medical examination or diagnosis. Test results do not represent or imply that I MAY or MAY NOT be at risk for sudden cardiac death. Although an echocardiogram cannot definitely diagnose hypertrophic cardiomyopathy, it may indicate levels of probability of having or not having hypertrophic cardiomyopathy.

CONFIDENTIALITY: As part of this screening, I agree to allow physicians, medical personnel, and staff of both LPCF/PCA to have access to my medical records from this screening. I allow LPCF/PCA and its physicians, medical personnel, and staff to contact me in regards to my participation in this screening program. I also authorize LPCF/PCA to use this information, including the results of this screening test for statistical evaluation; however, I understand that I will not be individually identified in any recognizable way. The results of the screen will be released to me, and the confidentiality of my medical records will be maintained.

TEST RESULT NOTIFICATION: A pediatric cardiologist at PCA will read every test 2-3 weeks following the screens. ***If there are any results other than normal, a doctor or physician assistant will contact the parent of the student directly. If the results are normal, LPCF will mail a letter to the address provided on this form, indicating a normal test to the students' parents.*** Please allow 3-4 weeks for test results. Screen results are NOT provided directly to schools.

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. It is my responsibility to discuss the results of the screening with my primary care

physician and, if indicated, begin a medically approved modification program based on the findings and recommendations of my primary care physician.

If I do not have a primary care physician, I understand that I am strongly encouraged to engage the services of a primary care physician to review the results of an abnormal screen and to determine my follow-up healthcare needs. The physicians of PCA are not primary care physicians and, therefore assume no responsibility or liability relative to my follow-up care. Should I receive notice of an abnormal screen, I understand that any delay on my part to follow-up with my primary care physician in a timely manner could result in adverse health consequences.

I hereby authorize PCA to release the results of my screening test to the primary care physician indicated on the history form contained in Part 3 below. This authorization may be revoked at any time by submitting a written notice to **PCA, 7777 Hennessy Blvd., Suite 103, Baton Rouge, Louisiana 70808**. The release of my Protected Health Information by PCA shall at all times be governed by PCA's Notice of Privacy Practices, which I have received a copy of as Part 4 of this form.

CONSENT, AGREEMENT, AND WAIVER: I have read, understand, and accept this Notice, informed Consent and Release. I have had the opportunity to ask questions and my questions have been answered in a satisfactory manner. I have been informed as to the purpose of this screening and I freely consent to be a participant in the screen. I understand and assume all risks associated with my participation in this screen program. **I understand that the screening program will only screen for abnormalities in my heart for genetic heart condition, and does not constitute a complete medical exam or diagnosis. I understand abnormal test results do not represent or imply that I DO or DO NOT have a heart condition.** By signing this consent and waiver, I hereby agree to waive any legal claim against LPCF and their directors, officers, employees and agents (collectively "Indemnified Parties"), and I further agree to indemnify and hold harmless the Indemnified Parties from and against any claim, loss, damage, cost, expense (including reasonable attorney's fees) or liability arising out of or related to the failure of the screening and/or the corresponding interpretation of the results to detect heart disease, abnormalities or any other illness.

For a diagnosis of a medical problem, I acknowledge that I must see a physician for a complete medical examination. I understand that I am responsible for my own health. I understand that I am responsible for all follow-up examinations to check abnormalities found during this screening. I am financially responsible for the cost of any follow-up care, treatment, and/or procedures whether or not covered by my insurance. I received a copy of this Notice, Informed Consent and Release prior to treatment by Pediatric Cardiology Associates. I understand and agree to the use of information from medical records in accordance with the limitations set forth in this consent form and the Notice of Privacy Practices attached as Part 4 of this form.

Having read this Notice, Informed Consent and Release, and in consideration of LPCF accepting me for participation in this screen program, I, for myself and for anyone on whose behalf I am entitled to act, release LPCF/PCA, its physicians, medical personnel, agents, and sponsors from all claims of any kind arising out of my participation in this screening program.

Signature of Student/Participant Date

Signature of Parent/Guardian Date

Part 3. Medical History (to be completed by student or parent)



Louisiana
Pediatric
Cardiology
Foundation

Explain “yes” answers below. Circle any questions that you do not know the answer to.

Student’s Name (First & Last): _____ Date of Birth: _____

Primary Care Physician (PCP): _____ PCP Phone #: _____

1. Has it been more than two years since you had a physical exam that included a blood pressure reading and listening to your heart?	YES	NO
2. Have your parents or has a physician ever told you that you have a heart murmur?	YES	NO
3. Has a physician ever suggested that you not participate in athletic competition?	YES	NO
4. Have you had a chest pain/pressure, dizziness, or racing or “skipped beats” at rest or with exercise?	YES	NO
5. Have you ever fainted or passed out <i>during</i> exercise or after having been startled?	YES	NO
6. Have you ever fainted or passed out <i>after</i> exercise?	YES	NO
7. Have you ever been told that you have high blood pressure, high cholesterol, or diabetes?	YES	NO
8. Have you ever been diagnosed with unexplained seizures or exercise-induced asthma?	YES	NO
9. Do you use or have you ever used cocaine or anabolic steroids, or do you smoke?	YES	NO
10. Has anyone in your family had sudden, unexpected death before 45?	YES	NO
11. Has anyone in your immediate family had unexplained fainting or seizures?	YES	NO
12. Has a physician diagnosed anyone in your family with an abnormally thickened heart, weakened heart, or Marfan syndrome?	YES	NO

If the answer to any of the above questions is “yes”, please give more details: _____

Signature of Student: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____