Student heart check

Program Consent

Student's name _____

Program goals:
Beaumont is offering a community-based screening program for high school students. Cardiovascular pre-participation screening is the systematic practice of medically evaluating large, general populations of athletes prior to participation in sports for the purpose of identifying or raising suspicion of abnormalities that could provoke disease progression or sudden death (AHA Scientific Statement 2007).

The purpose of the screening is to attempt to identify any pre-existing heart conditions that could potentially increase the student's risk of vigorous physical activity and/or athletic competition.

Screening consent:
I understand that the screening examination and tests offered by Beaumont do not diagnose cardiac disease, and that any sign or symptom found means that my child needs further medical evaluation (full history, physical examination and diagnostic testing) to determine the cause of the sign or symptom. Additionally, I understand that Beaumont will notify me of the findings. I understand that Beaumont will not provide any further tests or follow-up care without a medical professional order or referral after this screening. I also understand that it is my responsibility to arrange for my child's follow-up care if indicated, and that this screening is not a substitute for a complete pre-activity/athletic competition evaluation by my child's physician.

I consent to my child receiving the following screening evaluation:

- **Medical history**
  - pre-printed questionnaire
  - completed by parents prior to screening day
- **Vital sign monitoring:** Clinical staff will obtain blood pressure and review medical history information
- **Electrocardiogram (ECG):** Performed at rest with patches placed on surface of skin. The test maps the rate, rhythm and functions of the heart, and prints a tracing for physician review and interpretation.
- **Physician review and examination:** A physician will review the screening findings as described above and perform a limited physical examination.
- **Echocardiogram (quick look):** A screening echocardiogram is an ultrasound image created by using a Doppler wand across the chest.

I understand that a written report of the screening findings will be provided at the end of the screening. I agree that Beaumont is not responsible to arrange for any further tests or care for my child, and has made no guarantees or promises to me related to the screening provided. The data we collect may be used by Beaumont researchers to add to the scientific knowledge of sudden cardiac arrest in young athletes. The data will be reported anonymously. Student privacy and confidentiality will be maintained

Printed Name:_____ Signature:_____Date: _____

Address: _____ Email: _____

Phone Number: _____

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Health History Questionnaire

Student's Name _____ Birthdate _____AGE_____

Height _____ Weight _____ Gender _____

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. Has a physician or your parents 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 chest pain/pressure, dizziness or racing or "skipped beats" at rest or with exercise?	YES	NO
5. Have you ever fainted or passed out during exercise or after having been startled?	YES	NO
6. Have you ever fainted or passed out after 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 age 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
13. Are you on a school or organized sports team?	YES	NO

14. What sport(s) do you plan on playing? _____

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

_____

_____

Answered by:

_____ _____

Student Signature (date) Parent/Guardian Signature (date)

Beaumont HEALTH

AUTHORIZATION FOR PATIENT PHOTOGRAPHY, RECORDINGS AND/OR INTERVIEWS

I authorize this release of personal health information by William Beaumont Hospital, Oakwood Healthcare and Botsford Hospital ("Beaumont Health") and/or any of its divisions, affiliates or agents based on the following conditions:

- This release/authorization applies to protected health information in the form of photographs, audio, video, digital and film recording of me, my minor child, and/or another person for whom I am legal representative.
- These images or written materials become the property of Beaumont, the news media or other parties to whom they are released, including copyright.
- I release Beaumont Health or any of its divisions, affiliates, medical staff, employees or agents from any and all liability including any claims of libel or invasion of privacy connected with or resulting from these images or written materials. I understand that I am not required to sign this form and refusing to sign will not affect my care. I have the right to stop recording or interviewing at any time.
- I understand that news media and other third parties are not covered by federal privacy regulations and that the information described above will likely be re-disclosed and no longer protected by the federal privacy regulations or State law.
- This release is given without promise of compensation or royalties.

I agree to the following: (*check all that apply*)

☐ Take and/or publish photographs or audio/videotape recordings of me and/or my minor child and/or other person, for whom I am the legal representative.

☐ Interview, disclose and/or publish information about me and/or my minor child or other person for whom I am the legal guardian about care as a patient at Beaumont Health, including diagnosis, nature and/or extent of injuries or illness.

The photographs, audio/video recordings and/or information can be used in:

☐ Internal or external publications, including news releases, websites and social media

☐ Advertising, marketing or fundraising materials

☐ Allow the news media or other third parties to interview, take photographs or recordings and publish or broadcast (without right of review) personal health information regarding care provided to me and/or my minor child, and/or another person for whom I am the legal representative.

This authorization is effective until revoked in writing by the undersigned. Such revocation will only prevent any future use of the images or written materials. Send a written revocation to: Beaumont Health Corporate Privacy Officer, 26901 Beaumont Blvd, Southfield, MI 48033.

A copy of this form will be provided upon request.

(Please Print)

Patient Name_____ Date of Birth_____

Address_____ City, State, Zip_____

Phone _____-_____-_____ Email_____

Patient Signature (or parent/legal representative) _____ Date _____

Parent/Legal Representative Name (please print) _____

For internal use only:

Description: _____ Purpose: _____

Media: _____ Beaumont Health Rep: _____