NoTF ID Number _____

Do you ride the bus? Yes ☐ No ☐

HEART HEALTH SURVEY

CONTACT INFORMATION

Student Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Date of birth:_____

Home Phone:_____ Parent's Mobile Phone:_____

Parent/ Guardian Name: _____

Parent/ Guardian Email Address:_____

The Nick of Time Foundation 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 deductable, and can be made by cash or check payable to:
Nick of Time Foundation

Or by online donation at: www.nickoftimefoundation.org/donate/

NoTF ID Number _____

COMMUNITY HEART SCREENING

AGREEMENT TO PARTICIPATE IN HEART SCREENING

The Nick of Time Foundation 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 the Nick of Time Foundation 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 The Nick of Time Foundation and medical personnel to provide your screening results to your physician or cardiologist, and you authorize your physician to share the results and diagnosis of any subsequent testing with The Nick of Time Foundation.

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 Nick of Time Foundation 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 The Nick of Time Foundation 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 The Nick of Time Foundation, all physicians, technicians, volunteers, and all other persons, entities, individuals, and organizations harmless and waive all subrogation rights against The Nick of Time Foundation 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 The Nick of Time Foundation 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

ID Number:_____

Please complete the following questions regarding the individual being screened:

DEMOGRAPHICS

Age:_____

Gender: ☐Male ☐Female

Race: (check all that apply)

☐White
☐Black or African-American
☐Asian
☐Native American or Native Alaskan
☐Native Hawaiian or Other Pacific Islander
☐Other: please specify:_____

Ethnicity: (check one)

☐Hispanic or Latino
☐Not Hispanic or Latino

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 <u>competitively or on an organized team</u>?

(check all that apply)

☐Baseball
☐Basketball
☐Cheer
☐Cross country
☐Cycling
☐Football
☐Field hockey
☐Fencing
☐Frisbee
☐Golf
☐Gymnastics
☐Hockey
☐Lacrosse
☐Martial arts
☐Rowing
☐Rugby
☐Soccer
☐Softball
☐Skiing
☐Squash
☐Swimming/Diving
☐Tennis
☐Track
☐Volleyball
☐Wrestling
☐Other:_____

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

ID Number:_____

PAST MEDICAL HISTORY

Do you have any ongoing medical conditions? ☐Yes ☐No

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

☐Pre-existing heart condition_____

☐Other:_____

Are you taking any medication? ☐Yes ☐No

If yes, what medication?_____

Have you had a sports physical or well child evaluation by a physician or other medical provider within the last 12 months? ☐Yes ☐No

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HEART HEALTH QUESTIONS	*Student*		*(If "Yes") After Physician Review*	
	No	**Yes**	*No*	*Yes*
1. **Have you ever passed out DURING exercise?** (For example, while running or playing sport – not after)				
2. **Do you get chest pain DURING exercise that makes you stop exercising?** (For example, pain in the center or left side of your chest – not right side)				
3. **Have you ever passed out or had a seizure suddenly and without warning in response to loud noises such as doorbells, alarm clocks, or ringing telephones?**				
4. **Has a close family member (parent, brother/sister, grandparent, aunt or uncle) died from a heart problem or suffered sudden cardiac arrest before the age of 40?**				
5. **Does a family member have any of these genetic* heart conditions:** ☐ Hypertrophic cardiomyopathy (HCM) ☐ Dilated cardiomyopathy (DCM) ☐ Arrhythmogenic right ventricular cardiomyopathy (ARVC) ☐ Marfan syndrome ☐ Long QT syndrome (LQTS) ☐ Catecholaminergic polymorphic ventricular tachycardia (CPVT) ☐ Brugada syndrome *Does not include atrial fibrillation, congestive heart failure, coronary artery disease/heart attacks, or supraventricular tachycardia.				

Physician comments:_____

_____