

Ht _____ Wt _____ Place ID Sticker here
B/P _____ HR _____ Date of Screening _____

SPARKLING ANGEL CHARITIES
The Kelly Weaver Memorial Fund

Long QT Syndrome Screening Form ***{2 sides}*******

Confidential

Name: _____ Age: _____ Sex: M F
(Last) (First)

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Parent's cell phone: () _____

Date of birth: _____ Grade: _____ School/Location: _____ Graduation year: _____

Primary Physician _____ Physician's phone: () _____

Race: (Optional) ___ Asian ___ African-American
___ Caucasian ___ Hispanic
___ Other _____

How many times per week do you exercise strenuously for 30 minutes or more? _____

CHECK SPORT/ EXERCISE PARTICIPATION:

___ BASEBALL ___ BASKETBALL ___ CHEERLEADING ___ CROSS-COUNTRY
___ DIVING ___ FIELD HOCKEY ___ FOOTBALL ___ GOLF
___ HOCKEY ___ SOCCER ___ SOFTBALL ___ SONG/DANCE
___ SWIMMING ___ TENNIS ___ TRACK/FIELD ___ WATER POLO
___ WRESTLING ___ VOLLEYBALL OTHER _____

List any over the counter medication, prescriptions, including inhalers, vitamins or herbal medication you have taken in the last 3 months:

1. _____ 3. _____
2. _____ 4. _____

*** PLEASE CONTINUE TO SIDE 2 ***

PARENT/GUARDIAN – PLEASE ANSWER THE FOLLOWING QUESTIONS

Has the Student/Athlete ever been hospitalized overnight? (Circle) YES NO

Diagnosis_____

Family History:

Does the student/athlete have a family history of: (Circle) YES or NO

- | | | |
|---|---|---|
| 1. Fainting | Y | N |
| 2. Near Fainting | Y | N |
| 3. Dizziness | Y | N |
| 4. Seizure | Y | N |
| 5. Hearing disorder or deafness | Y | N |
| 6. Has any family member ever died of a sudden death? | Y | N |

Student/Athlete's Personal History of Symptoms:

Does the student/athlete have a history of: (Circle) Yes or No

- | | | |
|--|---|---|
| 1. Fainting? Cause? _____ | Y | N |
| 2. Near Fainting? Cause? _____ | Y | N |
| 3. Dizziness during exercise? | Y | N |
| 4. Seizure? | Y | N |
| 5. Hearing disorder or deafness? | Y | N |
| 6. Eating disorder? | Y | N |
| 7. Skipped heart beat or irregular heart beat? | Y | N |
| 8. Rapid heartbeat or a sensation like your heart is racing? | Y | N |
| 9. Become tired more quickly than peers during exercise? | Y | N |
| 10. Are you under a doctor's care for your heart? | Y | N |
| 11. Have you ever had an EKG before? | Y | N |

Has any family member died of sudden death other than by an accident or trauma before the age of 55? Y N

If YES, please explain:_____

Parent/Guardian Signature_____

Parent/Guardian Name Printed_____

Student/Athlete Signature_____

For SAC Use:

Sparkling Angel Charities
The Kelly Weaver Memorial Fund

This event is sponsored by a nonprofit charitable organization for the benefit of our community. Participants will be offered an EKG screening and by doing so we hope to increase the community's awareness of Long QT Syndrome and to eventually screen all local young people. This screening is being provided to detect Long QT Syndrome and not for the purpose of diagnosing or treating any particular health condition that you or your child may have. A qualified medical professional will read your child's EKG. You will not be notified of you or your child's EKG unless the results are abnormal. If the EKG results are not within normal limits, you will be notified in writing, given a copy of the EKG, and strongly encouraged to seek a medical attention. It is important to know that you or your child may suffer from a medical condition which may not be detected by this EKG screening. If you have any concerns about you or your child's health, contact your personal health care provider immediately. You understand that it is your decision as to whether or not you or your child participates in this EKG screening. No physical examination will be provided to determine whether there are risks to you or your child. By participating in this EKG screening you are assuming all risks of the screening on behalf of your child, and you are waiving any claim that you or your child's heirs may have as a result of participating in this screening. The information we collect from this event may be used for research purposes, and if so, all individual identifying information will be removed.

STATEMENT OF CONSENT/RELEASE OF LIABILITY

I hereby give my consent for myself or my child to undergo an EKG screening. I understand that the persons providing this screening are volunteers and will not be providing medical advice. I understand that I am assuming full responsibility for any risks or complications that may arise as a result of undergoing this screening. I further understand that the results of the screening are for the detection of Long QT Syndrome and not for the purpose of diagnosing or treating any medical condition that I or my child may have. I hereby release Sparkling Angel Charities and all agents, representatives, and volunteers, from any liability, individually and collectively, from any and all claims, including negligence, which may be asserted by me or my heirs arising from, or relating to my participation in this screening. I have read the foregoing and agree to all the terms and conditions.

Participant's Name (Printed)

Date

Parent/Guardian Signature

Parent/Guardian Name – Please PRINT

I have received, read and understand the following: (Please initial each item)

- _____ Parent Information Sheet
- _____ Long QT Syndrome Screening Form
- _____ Patient Statement of Consent/Release of Liability
- _____ Sparkling Angel Charities Participant Privacy Notice (HIPPA) information form.
- _____ In the event of an abnormal EKG, 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 understand that my child's EKG data may be used in a future medical study. I give my permission to physicians associated with Sparkling Angel Charities to contact my child's physician in the event they have questions pertaining to my child's follow up care.

Your child's personal information is secure as Sparkling Angel Charities complies with the Health Information Privacy Protection Act (HIPPA).

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PARENT INFORMATION SHEET

What is an ECG (or EKG)?

ECG and EKG are abbreviations for electrocardiogram, which is a graphic tracing of the electrical activity of one's heart. It is a simple, fast and noninvasive way to record the heart's electrical activity (heartbeat). You will NOT be shocked.

What is an ECG screening?

An ECG screening of the heart is much the same as a vision or hearing screening. It is not intended to be a diagnostic session, but to raise a red flag to identify overt potential problems.

Why are we offering free ECG Screenings to local high schools?

To increase awareness of Long QT Syndrome (LQTS) and to detect if any student may have LQTS.

What is Long QT Syndrome?

LQTS is a disturbance of the heart's electrical system causing an abnormality of the heartbeat, or rhythm, of the heart. Affected people are vulnerable to sudden fainting (syncope) and even death. Many times the cause of syncope is overlooked and the events are called simple fainting spells or seizures. Most often these events occur during physical exertion or emotional stress. In some, they occur during sleep. Most of these deaths are preventable if the condition is recognized and treated.

How is LQTS detected?

By an ECG that is read by a cardiologist or electrophysiologist, not by a computer print out. Further testing may be necessary to accurately diagnose LQTS.

Who will be doing the ECGs?

Volunteers of Sparkling Angel Charities who have been trained and certified to perform ECGs.

Is my child required to participate?

No.

What should my child wear?

Comfortable, loose fitting clothing. Girls: Please do not wear dresses, pantyhose, sports bras or body lotion. Do wear a two-piece style bathing suit top or bra without under wires under your blouse.

Will privacy be provided?

Yes. Boys and girls will be screened in separate areas and only females will screen girls.

Could my child have a heart condition that is not detected by this screening? It's possible. A normal ECG indicates - at this time - a low risk factor for sudden cardiac death, but it is not infallible. Please consult your family physician if you feel your child might have a problem.

What if the ECG is abnormal?

A letter and copy of your child's ECG will be sent directly to your home address so that you may seek medical advice from your own physician. Your child's school will not be notified. It is your responsibility to follow-up with a board certified physician.

So, if I don't receive a follow up letter, can I assume the ECG was normal?

If you do not hear from Sparkling Angel regarding the outcome of the ECG it means that our physicians did not observe any overt abnormality. If our physicians detect an overt abnormality you will be notified in writing with the recommendation to see your physician or cardiologist/electrophysiologist for follow-up evaluation.

What do I have to do for my child to participate in the ECG screening?

Your child must bring the following completed and signed forms to the screening:

- 1) Consent/Release of Liability Form**
- 2) ECG Screening Form**

Your disclosure of honest, complete and accurate information is extremely important.

Questions? Please refer to our website for more information.

www.SparklingAngel.org