September 23, 2013

Dear Student and Parent:

A Heart Screening Program will be conducted for Crook County student athletes who are in grades 9-12 on Wednesday, February 12th 2013. This program is jointly sponsored by the Children's Heart Fund of St. Charles Foundation and St. Charles Cardiovascular Services.

The Heart Screening will include an electrocardiogram (EKG), which is a test that checks for problems with the electrical conductivity of the heart, and a limited echocardiogram which is an ultrasound that provides a two dimension image of the heart. These tests will be focused on detection of some of the heart conditions that can lead to sudden death in young people. These conditions may include abnormal thickening of the heart muscle, enlargement of the aorta (the main blood vessel that leaves the heart), operation of the heart valve and electric conduction of the heart. These abnormalities are rare and may easily be missed on a routine physical exam. Please note that the Heart Screening is not a substitute for your son or daughter's required sports physical or for a complete cardiac evaluation.

If you choose to have your son or daughter participate in the screening programs, the above tests will be performed by a qualified caregiver and the results will be reviewed by a cardiologist. Because of the time required to review the large number of tests, it may take up to eight weeks for the results to be available. You and your child's physician will be notified of test results by mail. In the event of a borderline or abnormal finding, further cardiac evaluation may be recommended. In that case, you or your insurance company would be responsible for payment for any further testing.

In order to participate in the Screening Program, your teenager must first return a signed consent form and student information form. This free screening will be done on a first come, first served basis. Please read the enclosed consent form carefully before signing. Consent forms and information forms should be returned to your son or daughter's school or to the St. Charles Foundation two weeks prior to the screening. Prompt return of consent forms will assist us in planning for the number of students who will be participating.

Thank you for your consideration. We are committed to providing this service to the students in our community. Our hope is to make this a regular event so that we can help to ensure the health of our teens. If you have any questions please feel free to contact the Children's Heart Fund at 541-706-2787.

STUDENT HEART SCREENING
CONSENT FORM

Student's Name: _____ Date of Birth: _____

Students participating in the Heart Screening Program will have their height, weight and blood pressure measured. They will also have an EKG and a brief, limited echocardiogram. These tests will be focused on detection of specific heart abnormalities, including hypertrophic cardiomyopathy (an abnormal thickening of the heart muscle) an abnormal enlargement of the aorta (the main blood vessel that leaves the heart), certain heart valve abnormalities, and abnormal electrical conduction in the heart. These abnormalities may be missed on a routine physical examination. Participation in this screening program is completely voluntary.

1. I and my child hereby give consent for my child to participate in the Heart Screening Program.

2. I and my child understand that my child's primary physician, as identified on the student information form, will be informed of the results of the screening tests.

3. I and my child understand that the screening test is not a substitute for a complete cardiac evaluation or a sports pre-participation physical.

4. I and my child understand that the screening test will not identify all possible heart abnormalities.

5. I and my child understand that some heart abnormalities are progressive over time; therefore, a "normal" heart screening now does not guarantee that there will be no abnormalities in the future.

6. I and my child understand that if certain heart abnormalities are identified, restriction from competitive sports may be recommended for my child.

7. I and my child understand that if the screening test is not normal, it will be my responsibility to discuss the results with my child's physician and to follow any recommendations for further testing or treatment. This testing and follow-up care will be my financial responsibility.

8. I and my child understands that the EKG requires use of patches placed on the surface of skin and that the echocardiogram requires use of a lubricant and that both the patches and lubricant may cause a minor, temporary skin irritation in persons with hypersensitivity.

9. I and my child agree for myself, my heirs, administrators, and executor to hereby release, hold harmless, and indemnify, St. Charles Health System, Inc ("SCHS"), St. Charles Heart and Lung Center, AND ITS STAFF, SCHS's affiliated entities, and all of the foregoing entities' officers, directors, employees, agents, insurers and related parties, from any and all liability for any loss, injury, or damage arising out of or in connection with my child's participation in this program.

10. I and my child have carefully read this Student Heart Screening Consent form and know and understand its contents.

11. I understand it is a full release of all liability and I sign it of my own free will.

12. I agree that this student Heart Screening Consent form shall be governed by and construed according to the state of Oregon.

Name of Student (please print): _____

Students Signature: _____Date: _____

Name of Parent/Guardian (please print): _____

Parent/Guardian's Signature: _____ Date: _____

STUDENT INFORMATION FORM

Student's Name: _____

Date of Birth: _____ Age: _____ Sex: □ Male □ Female

Name(s) of Parent(s)/Legal Guardian(s) living with Student: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Mobile Phone Number: _____

Name of Student's Physician: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Sport(s) in which student regularly participates: _____

School student attends: _____

Does the student have and known history of heart problems?	□ Yes	□ No
Does the student have a known heart murmur?	□ Yes	□ No
Does anyone in the student's family have a history of heart defects?	□ Yes	□ No
Has anyone in the student's family been diagnosed with heart rhythm abnormalities at a young age?	□ Yes	□ No
Did anyone in the student's family die suddenly at a young age?	□ Yes	□ No

Please explain any "Yes" responses: _____

Student's Signature: _____ Date: _____

Name of Parent/Guardian (please print): _____

Parent/Guardian's Signature: _____Date: _____

For Cardiologist Use Only:

Date of Screening:

Student's Name: _____ Age: _____

BSA: _____m2

Height (*cm)*: _____ Weight (*kg)*: _____

B/P: _____ B/P %tile: _____

EKG: □ Normal □ Abnormal □ Borderline

QTc= _____sec

Comments:

ECHO:

IVSd = _____cm □ Normal □ Abnormal □ Borderline

Comments:

Ao Root: □ Normal □ Abnormal □ Borderline

SV: _____cm

SAR: _____cm

Comments:

Ao valve: □ Normal □ Abnormal □ Borderline

Comments:

Other:

_____

_____

_____