

Ht \_\_\_\_\_ Wt \_\_\_\_\_  
B/P \_\_\_\_\_ HR \_\_\_\_\_

Place ID Sticker here

Date of Screening \_\_\_\_\_  
Location of Screening \_\_\_\_\_

## SPARKLING ANGEL CHARITIES - The Kelly Weaver Memorial Fund

**\*\*TWO SIDES\*\* Health History - Long QT Syndrome Screening Form \*\*\*TWO SIDES\*\*\***

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

(Last) (First)  
Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Parent's cell phone: ( ) \_\_\_\_\_

Date of birth: \_\_\_\_\_ Grade: \_\_\_\_\_ School/Location: \_\_\_\_\_ Graduation year: \_\_\_\_\_

Primary Physician \_\_\_\_\_ Physician's phone: ( ) \_\_\_\_\_

Race: \_\_\_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. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

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

\*\*\*\*\*PLEASE CONTINUE TO SIDE 2, COMPLETE AND SIGN\*\*\*\*\*

# 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 Golden West Community College, Coastline Community College District, 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.

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

\_\_\_\_\_ Parent Information Sheet (FAQs)

\_\_\_\_\_ Health History - Long QT Syndrome Screening Form

\_\_\_\_\_ Patient Statement of Consent/Release of Liability

\_\_\_\_\_ Sparkling Angel Charities Participant Privacy Notice (HIPPA) information.

\_\_\_\_\_ 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 evaluation, 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.

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**Participant's Name – Please PRINT**

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**Parent/Guardian Signature**

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**Parent/Guardian Name – Please PRINT**

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