

Record Number: _____

ATHLETE / STUDENT CARDIOVASCULAR QUESTIONNAIRE
The Nick of Time Foundation Cardiac Screening

NAME _____ AGE _____ MALE ___ FEMALE _____

HEIGHT _____ WEIGHT _____ RACE: Black ___ Hispanic: ___ White: ___ Asian: ___ Indian: ___ Other: ___

DATE OF BIRTH _____ SCHOOL _____ GRADE _____

CHECK SPORTS (S) PARTICIPATION: Competitive Athlete: ___ Yes ___ No

___ Baseball ___ Basketball ___ Cheerleading ___ Cross Country ___ Football ___ Golf
___ Tennis ___ Song/Dance ___ Soccer ___ Softball ___ Track/Field ___ Swimming
___ Diving ___ Lacrosse ___ Wrestling ___ Volleyball ___ Other _____

PARENT & STUDENT TOGETHER – PLEASE ANSWER # I, II & III. PARTICIPATION SIGNATURE REQUIRED.

I - PAST HISTORY

Has the Student/Athlete:

1. Been hospitalized overnight? Yes ___ No ___
2. Had any chronic illness? Yes ___ No ___
What Illness? _____
3. Taken medication including over-counter meds or inhalers? Yes ___ No ___
What Medication? _____
4. Had any surgery? Yes ___ No ___
What Surgery? _____
5. Had any serious medical illness? Yes ___ No ___
What Medical Illness? _____
6. Had any allergies? Yes ___ No ___
What Allergies? _____
7. Had any psychiatric illness? Yes ___ No ___
8. Been told to limit participation in sports? Yes ___ No ___
Why? _____

II - CURRENT STATUS

Is the Student/Athlete:

1. Under the active care of a physician? Yes ___ No ___
For What Illness? _____
2. Taking any medication? Yes ___ No ___
What Medication? _____
3. Overweight for height / age? Yes ___ No ___
4. Drinking alcohol? Yes ___ No ___
5. Smoking cigarettes? Yes ___ No ___
6. Use performance enhancing agents? Yes ___ No ___

III - CARDIAC SIGNS / SYMPTOMS / FAMILY HISTORY

(Please have both parent and student complete)

- | | | |
|---|---------|--------|
| 1. Has student gotten dizzy or passed out during exercise? | Yes ___ | No ___ |
| 2. Has student ever passed out when startled or when feeling emotion? | Yes ___ | No ___ |
| 3. Does anyone in your family have unexplained fainting or seizures? | Yes ___ | No ___ |
| 4. Has student experienced chest pain, shortness of breath or wheezing? | Yes ___ | No ___ |
| 5. Become tired more quickly than peers during exercise? | Yes ___ | No ___ |
| 6. Has student ever had unusual or extreme shortness of breath during exercise? | Yes ___ | No ___ |
| 7. Been told that he/ she has a heart murmur or heart disease? | Yes ___ | No ___ |
| 8. Been told that he / she has skipped heartbeats or racing heartbeats? | Yes ___ | No ___ |
| 9. Has student ever had discomfort, pain or chest pressure when active? | Yes ___ | No ___ |
| 10. Does student get any discomfort in chest when sedentary? | Yes ___ | No ___ |
| 11. Has anyone in the family developed heart disease or died
from heart disease under the age of 50? | Yes ___ | No ___ |
| 12. Has anyone in the family had unexplained fainting or seizures? | Yes ___ | No ___ |
| 13. Have there been unexpected, unexplained deaths before 50,
in your family- includes car accident, SIDS, drowning, others? | Yes ___ | No ___ |
| 14. Has student ever been told they have high blood pressure? | Yes ___ | No ___ |
| 15. Chest pain or pressure: When? (walking, resting anytime) | Yes ___ | No ___ |
| 16. Palpitations: When? (walking, resting anytime) | Yes ___ | No ___ |
| 17. Shortness of Breath: When? (walking, resting anytime) | Yes ___ | No ___ |
| 18. Ankles / Leg Swelling: When? (walking, resting anytime) | Yes ___ | No ___ |
| 19. Unusual Fatigue: When? (walking, resting anytime) | Yes ___ | No ___ |
| 20. Light-headed / dizzy: When? (walking, resting anytime) | Yes ___ | No ___ |

Street Address _____

City: _____ **St:** _____ **Zip:** _____

Home Telephone: (_____) _____

Parent/ Guardian Email Address _____

Record Number: _____

THE NICK OF TIME FOUNDATION COMMUNITY CARDIOVASCULAR SCREENING

AGREEMENT TO PARTICIPATE IN CARDIOVASCULAR SCREENING

The Nick of Time Foundation is promoting a cardiovascular screening program to education athletes on cardiovascular disease and as an advocate to cardiac health. The Nick of Time Foundation will gather clinical information obtained from participants in the cardiovascular screening program designed for review by medical personnel at this event. The confidentiality of the identity of the screening participants obtained in the screening program will be preserved. The screening program may include:

1. Medical History Questionnaire
2. Blood pressure/Arterial Elasticity
3. Echocardiogram (Echo- an ultrasound of the heart, takes moving pictures of the heart)
4. Electrocardiogram (ECG- measures electrical activity in the heart)

Data Collection, Analysis and Reporting

The data collected related to your cardiovascular lifestyle screening used for the review of the medical personnel participating in our event will be used in an aggregate form (no names attached) in national data bank reporting. In agreeing to your cardiovascular screening, you understand that the information collected about you during the screening process, including the information contained in your medical health history questionnaire, will only be used in the assessment by the medical personnel at the cardiovascular screening. Medical personnel may provide you with the results of your initial screening and recommend ways to improve your medical condition through follow-up care, treatment and education.

By agreeing to participate in the program, if so indicated, you may also be giving your permission to The Nick of Time Foundation to provide your screening and medical history to your family physician or cardiologist. You authorize your physician to share the screening results and diagnosis with The Nick of Time Foundation. This information will be used in the aggregate form data ONLY.

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 cardiovascular 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 cardiac screening performed on this day. I understand that the cardiac portion of this test is to evaluate for Hypertrophic Cardiomyopathy, HCM, the leading cause of sudden cardiac death of young people in the USA.

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 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

**The Nick of Time Foundation is providing this Cardiac 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 deductible, and can be
made by credit card, cash or check payable to: The Nick of Time Foundation.
www.nickoftimefoundation.org**