



St. Francis Hospital  
Roslyn, NY

PATIENT IDENTIFICATION

## Student Athlete Heart Screening Consent

The student athlete screening initiative is part of the Outreach Program at St. Francis Hospital-the Heart Center™. The purpose of this initiative is to detect and assess potential cardiac abnormalities. All students that are interested in participating in this screening must have the following on hand the day of the screening:

- The following consent form completed/signed by a parent
- Proper picture ID
- Completed the patient history section of the screening form prior to assessment

If a cardiac abnormality is detected, information regarding follow up care and possible treatment plans will be provided.

During this assessment several non invasive diagnostic tests will be performed:

**EKG:** An electrocardiogram (EKG) is a test that checks for problems with the electrical activity of your heart. It translates the heart's electrical activity into line tracings on paper.

**Echocardiogram:** A diagnostic test that utilizes ultrasound techniques to provide a 2 dimensional image of the heart.

1. An electrocardiogram or EKG will be conducted to determine your son/daughter's heart rhythm/electrical activity through electrodes that will be placed on his/her chest.
2. An echocardiogram will be conducted on your son or daughter to get a visual image of your son or daughter's heart structure.
3. Findings from the EKG and echocardiogram conducted on your son or daughter will be available the same day and interpreted by a doctor, who will conduct an assessment.

I have read the above description outlining the intent of the student athlete heart screening program and non invasive diagnostic tests to be performed on my son or daughter. By signing this form, I am consenting to allow an EKG and echocardiogram to be performed and the interpretation and assessment conducted by a physician.

**Student's Name:** \_\_\_\_\_

**Relationship (Please circle):** Son or Daughter

**Name (of Parent or Guardian):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_

WHITE – OUTREACH YELLOW – DR. LEVCHUCK