playSmart™
Youth Heart Screenings

503-216-6800 • www.PlaySmartGetScreened.org

AGREEMENT TO PARTICIPATE IN HEART SCREENING

Providence Heart Institute is offering a heart screening program for ALL youth, ages 12-18. The information obtained from participants will be reviewed by medical personnel at the event. The identity of the screening participants will remain confidential and available only to Providence Health & Services and the medical personnel working with the Play Smart program. The heart screening may include:

1. Patient Questionnaire
2. Blood Pressure Reading
3. Height/Weight Reading
4. Electrocardiogram (EKG/ECG)
5. Echocardiogram - Ultrasound picture of the heart (**if necessary; scheduled as a separate appointment*)

The data collected related to your heart screen will be reviewed by medical personnel and may be used in an aggregate form (no names or identifiers) as part of a research study on heart screening in the young. In agreeing to your heart screen, you understand and provide permission that the information collected about you during the screening process, including the information contained in your medical questionnaire, will be reviewed by medical personnel and can be used for research purposes. Medical personnel will provide you with an unconfirmed copy of your EKG tracing, as well as information on how you will get screening results and program/contact information.

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Play Smart ID: _____

Consent for Participants Age 15 - 18:

I acknowledge that I have read the agreement to participate and understand its contents. Any questions have been answered to my satisfaction. I agree to be a participant in this heart screening, and in connection therewith, I consent to the release of information obtained in connection with the screening as described. I understand that Providence Health & Services 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 Providence Health & Services, all physicians, technicians, volunteers, and all other persons, entities, individuals and organizations harmless and waive all subrogation rights against Providence Health & Services and their directors, officers and volunteers as respects process and results of this free heart screening performed on this day.

If necessary, Providence reserves the right to provide a copy of the patient's questionnaire information and electrocardiogram to the patient's primary physician and/or pediatric specialist.

_____ _____ _____

Date Printed Name of Participant Signature of Participant

Parental/Guardian Consent for Participants Under the Age of 15:

As parent/guardian of the named minor participant, I acknowledge that I have read the 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. I understand Providence Health & Services 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. I further agree to hold Providence Health & Services, all physicians, technicians, volunteers, and all other persons, entities, individuals and organizations harmless and waive all subrogation rights against Providence Health & Services and their directors, officers and volunteers as respects process and results of this free heart screening performed on this day.

If necessary, Providence reserves the right to provide a copy of the patient's questionnaire information and electrocardiogram to the patient's primary physician.

_____ _____ _____

Date Printed Name of Participant Signature of Parent/Guardian

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