Student heart check

Program Consent

Student's name _____

Program goals:
Beaumont is offering a community-based screening program for high school students. Cardiovascular pre-participation screening is the systematic practice of medically evaluating large, general populations of athletes prior to participation in sports for the purpose of identifying or raising suspicion of abnormalities that could provoke disease progression or sudden death (AHA Scientific Statement 2007).

The purpose of the screening is to attempt to identify any pre-existing heart conditions that could potentially increase the student's risk of vigorous physical activity and/or athletic competition.

Screening consent:
I understand that the screening examination and tests offered by Beaumont do not diagnose cardiac disease, and that any sign or symptom found means that my child needs further medical evaluation (full history, physical examination and diagnostic testing) to determine the cause of the sign or symptom. Additionally, I understand that Beaumont will notify me of the findings. I understand that Beaumont will not provide any further tests or follow-up care without a medical professional order or referral after this screening. I also understand that it is my responsibility to arrange for my child's follow-up care if indicated, and that this screening is not a substitute for a complete pre-activity/athletic competition evaluation by my child's physician.

I consent to my child receiving the following screening evaluation:

- **Medical history**
  - pre-printed questionnaire
  - completed by parents prior to screening day
- **Vital sign monitoring:** Clinical staff will obtain blood pressure and review medical history information
- **Electrocardiogram (ECG):** Performed at rest with patches placed on surface of skin. The test maps the rate, rhythm and functions of the heart, and prints a tracing for physician review and interpretation.
- **Physician review and examination:** A physician will review the screening findings as described above and perform a limited physical examination.
- **Echocardiogram (quick look):** A screening echocardiogram is an ultrasound image created by using a Doppler wand across the chest.

I understand that a written report of the screening findings will be provided at the end of the screening. I agree that Beaumont is not responsible to arrange for any further tests or care for my child, and has made no guarantees or promises to me related to the screening provided. The data we collect may be used by Beaumont researchers to add to the scientific knowledge of sudden cardiac arrest in young athletes. The data will be reported anonymously. Student privacy and confidentiality will be maintained

Printed Name:_____ Signature:_____Date: _____

Address: _____ Email: _____

Phone Number: _____

Student heart check

Health History Questionnaire

Student's Name _____ Birthdate _____AGE_____

Height _____ Weight _____ Gender _____

1. Has it been more than two years since you had a physical exam that included a blood pressure reading and listening to your heart?	YES	NO
2. Has a physician or your parents ever told you that you have a heart murmur?	YES	NO
3. Has a physician ever suggested that you not participate in athletic competition?	YES	NO
4. Have you had chest pain/pressure, dizziness or racing or "skipped beats" at rest or with exercise?	YES	NO
5. Have you ever fainted or passed out during exercise or after having been startled?	YES	NO
6. Have you ever fainted or passed out after exercise?	YES	NO
7. Have you ever been told that you have high blood pressure, high cholesterol or diabetes?	YES	NO
8. Have you ever been diagnosed with unexplained seizures or exercise-induced asthma?	YES	NO
9. Do you use, or have you ever used, cocaine or anabolic steroids, or do you smoke?	YES	NO
10. Has anyone in your family had sudden, unexpected death before age 45?	YES	NO
11. Has anyone in your immediate family had unexplained fainting or seizures?	YES	NO
12. Has a physician diagnosed anyone in your family with an abnormally thickened heart, weakened heart or Marfan syndrome?	YES	NO
13. Are you on a school or organized sports team?	YES	NO

14. What sport(s) do you plan on playing? _____

If the answer to any of the above questions is yes, please give more details: _____

_____

_____

Answered by:

_____ _____

Student Signature (date) Parent/Guardian Signature (date)

Corewell Health™

PHOTO/INTERVIEW/MEDIA AUTHORIZATION FOR PATIENT

THIS IS NOT A PART OF A PATIENT'S MEDICAL RECORD. IF FOUND IN CHART, SHRED.

Patient name: Last _____ First _____

Date of birth ___/___/_____ Medical Record number (if known) _____

Address _____

Phone (_____)_____ Email _____

If patient is under 18 years old:
Parent/Guardian full name _____ Relationship to patient _____

Throughout this form:

"Company" will refer to Corewell Health/Priority Health and its employees, licensees, affiliates, contractors, successors, subsidiaries, and assigns.

"My/The patient's Likeness" will refer to photographs, quotes/excerpts of written or verbally expressed words, name, alias, biographical information, video and/or audio recording or other likeness of myself or the patient (if being completed by a parent or guardian on behalf of a minor or adult patient subject to guardianship).

I AUTHORIZE MY/THE PATIENT'S LIKENESS:

- To be created, obtained, used and shared by the Company for the reasons below: *(check all that apply)*
  - ☐ To advertise or promote the Company
  - ☐ To teach or inform the general public or health care professionals about health care/ Corewell Health/other related topics
  - ☐ Other reasons(s) _____
- To be copied/reproduced and distributed by means of various media, including, but not limited to:
  - Video presentation
  - Television broadcast/ re-broadcast
  - Social media
  - Radio transmission/ re-transmission
  - News release
  - Email
  - Mail
  - Billboard
  - Sign/poster/flier
  - Brochure
  - Placement on websites and/or other electronic delivery
  - Publication
  - Physical display
  - Other _____ _____
- To be reasonably modified or edited. I waive any right to inspect or approve the finished product or material in which the Company may use my/the patient's likeness.
- To be used and disclosed until:
  - ☐ _____ (date)
  - ☐ 10 years after today's date
  - ☐ The patient reaches 18 years of age (if for a minor patient)

NOTE: This authorization may be canceled (revoked) at anytime. If I want to cancel this authorization, I must send a request in writing to:

Corewell Health System, Chief Privacy Officer,
100 Michigan Street NE, Grand Rapids, MI 49503
OR
patient.privacy@corewellhealth.org (email)

I UNDERSTAND:

- My/the patient's likeness may include protected health information (PHI) connected with my/the patient's likeness.
- Once my/the patient's likeness is used and shared as allowed by this Authorization, the Company cannot prevent my/the patient's likeness from being re-used by someone other than the Company. I release the Company from any and all liability that may come directly or indirectly from the disclosure allowed by this Authorization and/or any re-use of my/the patient's likeness.
- I do not own the materials of my/the patient's likeness that are created, obtained, used, and shared as allowed by this Authorization. I understand the Company may receive money or other benefits from using my/the patient's likeness. I release the Company from any obligation to pay or benefit me/the patient from the use of my/the patient's likeness.
- I understand I do not have to sign this form. I can continue to get treatment from Corewell Health even if I do not sign this form.

I RELEASE FROM RESPONSIBILITY

The Company from any and all liability, claim, demand, and causes of action of any nature. This includes (but is not limited to) claims of negligence against the Company from (or in any way related to) the creating, obtaining, using and sharing of my/the patient's likeness.

I have read this form or it has been explained to me. All my questions about this form have been answered.

_____ ☐AM ☐PM _____ _____ _____ ☐AM ☐PM _____ _____
Time Date Patient Signature **TIME** **DATE** Witness to Signature

If a patient is under 18 years of age or otherwise unable to consent, the following must be completed:
I,_____, hereby certify that I am the _____
of the patient; that patient is unable to consent because patient is a minor, or because:

_____

_____ ☐AM ☐PM _____ _____ _____ ☐AM ☐PM _____ _____
Time Date Signature of Parent, Legal Guardian, Patient Advocate or Next of Kin **TIME** **DATE** Witness to Signature

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(FOR OFFICE USE ONLY)

Project number _____

Project description _____

Purpose of photo/video/audio/interview _____

_____

Corewell Health entity:

- ☐ Corewell Health System Communications and Marketing
- ☐ Corewell Health Foundation
- ☐ Other company entity(ies) (list) _____
- ☐ Other organization(s) (list) _____

Location where authorization was signed _____

Description of photo/video/audio/interview _____

☐ Copy of this form given to patient or child's parents/legal guardian

Corewell Health™

AUTORIZACIÓN DE(L)/LA PACIENTE: FOTO/ENTREVISTA/MEDIOS

ESTO NO ES PARTE PERMANENTE DE LA HISTORIA CLÍNICA DE(L)/LA PACIENTE. SI ENCUENTRA ESTE DOCUMENTO EN LA FICHA MÉDICA, TRITÚRELO.

Nombre de(l)/la paciente: Apellido _____ Nombre de pila _____

Fecha de nacimiento ___/___/_____ Número de historia clínica (si lo sabe) _____

Domicilio _____

Teléfono (_____)_____ Correo electrónico _____

Si el/la paciente es menor de 18 años de edad:

Nombre completo de madre/padre o tutor _____

Relación con el/la paciente _____

En todo este formulario:

"Compañía" se refiere a Corewell Health/Priority Health y sus empleados, licenciatarios, afiliados, contratados, sucesores, subsidiarias y asignados.

"Mi semejanza / La semejanza de(l)/la paciente" se refiere a fotografías, citas/extractos de palabras expresadas de forma escrita u oral, nombre, alias, información biográfica, grabaciones de audio y/o video o cualquier otra semejanza de mi persona o de(l)/la paciente (si esto está siendo completado por madre/padre o tutor legal en nombre de un(a) paciente menor o paciente adulto/a bajo tutela legal).

YO AUTORIZO QUE MI SEMEJANZA / LA SEMEJANZA DE(L)/LA PACIENTE:

- Sea creada, obtenida, usada y compartida por la Compañía por los motivos a continuación: (Marque todo lo que sea pertinente).
  - ☐ Para publicitar o promocionar la Compañía.
  - ☐ Para educar o informar al público general o a profesionales de la sanidad sobre temas de atención médica, Corewell Health y/u otros temas relacionados.
  - ☐ Otro(s) motivo(s) _____
- Sea copiada/reproducida y distribuida a través de varios medios, entre otros:
  - Presentación en video
  - Difusión/redifusión televisiva
  - Redes sociales
  - Transmisión/retransmisión radial
  - Comunicado de prensa
  - Correo electrónico
  - Correo postal
  - Cartel publicitario
  - Señal/póster/panfleto
  - Folleto
  - Sitios web y/u otros formatos electrónicos de difusión
  - Publicación
  - Exhibición física
  - Otro(s) _____
- Sea razonablemente modificada o editada. Yo renuncio a todo derecho de inspeccionar o aprobar el producto o material final en el que la Compañía pueda usar mi semejanza / la semejanza de(l)/la paciente.
- Sea usada y divulgada hasta:
  - ☐ El día _____ (fecha)
  - ☐ 10 años después de la fecha de hoy
  - ☐ La fecha en que el/la paciente cumpla 18 años (si es para un(a) paciente menor de edad)

NOTA: Esta autorización puede ser cancelada (revocada) en cualquier momento. Si yo deseo cancelar esta autorización, debo enviar una solicitud por escrito a:

Corewell Health System, Chief Privacy Officer
100 Michigan Street NE, Grand Rapids, MI 49503
O a:
patient.privacy@Corewellhealth.org (email)

YO ENTIENDO QUE:

- Mi semejanza / La semejanza de(l)/la paciente puede incluir información protegida relativa a mi/su salud vinculada con mi semejanza / la semejanza de(l)/la paciente.
- Una vez que mi semejanza / la semejanza de(l)/la paciente sea usada y compartida según lo permitido mediante esta Autorización, la Compañía no podrá evitar que mi semejanza / la semejanza de(l)/la paciente vuelva a ser usada por otra persona/entidad que no sea la Compañía. Yo libero a la Compañía de cualquier y toda responsabilidad resultante directa o indirectamente de la divulgación permitida por esta Autorización y/o todo nuevo uso de mi semejanza / la semejanza de(l)/la paciente.
- Yo no soy propietario/a de los materiales relativos a mi semejanza / la semejanza de(l)/la paciente que sean creados, obtenidos, usados y compartidos conforme a lo permitido por esta Autorización. Yo entiendo que la Compañía puede recibir dinero u otros beneficios como resultado del uso de mi semejanza / la semejanza de(l)/la paciente. Yo libero a la Compañía de toda obligación de pagarme a mí o pagar a(l)/la paciente por el uso de mi semejanza / la semejanza de(l)/la paciente.
- Yo entiendo que no tengo la obligación de firmar este formulario. Yo puedo continuar recibiendo tratamiento por parte de Corewell Health aun cuando yo no firme este formulario.

YO LIBERO DE RESPONSABILIDAD:

A la Compañía, de toda y cualquier responsabilidad, reclamación, demanda y causas de acción de cualquier naturaleza. Esto incluye, entre otras cosas, reclamaciones/alegaciones de negligencia contra la Compañía a raíz de (o de cualquier forma relacionadas con) la creación, la obtención, el uso y la divulgación de mi semejanza / la semejanza de(l)/la paciente.

Yo he leído este formulario o el mismo me ha sido explicado. Todas mis preguntas acerca de este formulario han sido respondidas.

_____ ☐ AM ☐ PM **Hora** _____ **Fecha** _____ Firma de(l)/la paciente

_____ ☐ AM ☐ PM **HORA** _____ **FECHA** _____ Testigo de la firma

Si el/la paciente es menor de 18 años de edad o si no puede dar su consentimiento por cualquier otra razón, debe completarse lo siguiente:

Yo, _____ , por la presente certifico que soy el/la _____ de(l)/la paciente; que el/la paciente no puede dar su consentimiento por ser menor, o porque: _____

_____ ☐ AM ☐ PM **Hora** _____ **Fecha** _____ Firma de(l) padre / la madre, tutor(a) legal, intercesor(a) por e(l)/la paciente o familiar más cercano

_____ ☐ AM ☐ PM **HORA** _____ **FECHA** _____ Testigo de la firma

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(SÓLO PARA USO INTERNO) ***(FOR OFFICE USE ONLY)***

Project number _____

Project description _____

Purpose of photo/video/audio/interview _____

_____

Corewell Health Entity:

- ☐ Corewell Health System Communications and Marketing
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- ☐ Other organization(s) (list) _____

Location where Authorization was signed _____

Description of photo/video/audio/interview _____

☐ Copy of this form given to patient or child's parents/legal guardian