Teen Athlete Cardiac Screening

Consent and Release

RANDALL CHILDREN'S HOSPITAL
LEGACY EMANUEL

I am the parent or guardian of the teen identified below. My teen and I wish to participate in Randall Children's Hospital at Legacy Emanuel's ***Teen Athlete Cardiac Screening***. I understand that Legacy Health will conduct a cardiac screening only, not a full cardiac evaluation. The Teen Athlete Cardiac Screening will include:

- ☐ Personal and family history
- ☐ Height and weight
- ☐ Electrocardiogram (ECG)
- ☐ BMI
- ☐ Blood pressure
- ☐ Cardiac health screening examination

In consideration of my teen's participation in the *Teen Athlete Cardiac Screening*, I understand and agree as follows:

I understand this is a limited screening for certain cardiac health conditions and does not constitute a complete diagnostic exam or medical diagnosis. I understand that some, but not all cardiac or heart-related problems, may be detected with this screening. I understand that some rare or intermittent heart problems may not be detected. I understand that my teen will still need to be cleared by a doctor or health care provider by having a physical before participating in a high school athletic program.

I understand the screening results will be reported to me with recommendations for follow-up if indicated. I understand the screening results may also be reported to my teen's primary care physician or health care provider listed below. The responsibility for initiating any follow-up examinations for abnormalities identified at the screening(s) lies with me as the responsible person and not with Legacy Health, adidas America, Inc. or the physician performing the screening.

I understand that any personal and medical information provided, such as age, address and medical condition(s), will be used only for identification and risk assessment purposes and will be kept in the strictest confidence, as will all information from my teen's screening. I understand this screening is being offered as a service to the community in general and not in connection with any services offered to patients of Legacy Health.

I understand that members of the media, including filming crews, may be present at the screening and that I will have the option of choosing whether or not to participate in media interviews and filming related to the screening.

I understand that Legacy will not retain a copy of the screening results as a medical record maintained by Legacy for services rendered to patients. I specifically acknowledge and understand that the examining physician involved in my screening may be an independent contractor, not an agent of or employed by Legacy Health or adidas America, Inc.

I wish and consent for my teen to participate in the Teen Athlete Cardiac Screening. In connection with the screening, I accept all risks associated with the screening and hereby release the examining physician, Randall Children's Hospital, Legacy Health, adidas America, Inc. and their employees and agents of all liabilities, medical claims, expenses and responsibility in connection with my participation in or with an injury sustained in connection with the screening(s).

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I agree for myself, my child, our heirs, administrators and executors to hereby release, hold harmless and indemnify, including cost of defense through trial and on appeal, all Legacy Health staff, Legacy Health, Legacy Health's affiliated entities, all adidas America, Inc. staff, adidas America, Inc., adidas America, Inc.'s affiliated entities, and all of the foregoing entities' officers, directors, employees, agents, insurers and related parties, from any and all liability for any loss, injury or damage, including without limitation, any claim for personal injuries resulting from or arising out of the health screening(s) even if Legacy Health or adidas, America, Inc. were made aware of such potential liability whether based on negligence, strict liability, contract or any other cause of action.

I have carefully read this Consent and Release form and know and understand its contents. I understand it is a full release of all liability and I sign it on my behalf and on behalf of my teen of my own free will. I also understand that the ***Teen Athlete Cardiac Screening*** is subject to change or cancellation without notice.

The following information must be completed (please print clearly):

Teen/student name _____

Birth date (month/day/yr) _____

Parent/guardian name _____

Street address _____

_____

City _____ Zip Code _____

10-Digit phone number _____ Email _____

Emergency contact name and phone number _____

Name of your doctor or health care provider _____

Your doctor or health care provider's address (list street address, city, zip code) _____

_____

_____

_____

Doctor or health care provider's 10-digit phone number _____

Teen/student signature _____ Date _____

Parent/guardian signature _____ Date _____