



Registration and Consent Form

NAME _____ SEX _____ AGE _____ DATE
OF BIRTH _____

SCHOOL _____ GRADE _____ PRIMARY CARE PHYSICIAN _____

PARENTS' NAMES _____ HOME PHONE _____

ADDRESS _____ PARENTS CELL # : _____

CITY/ZIP: _____ SPORT PLAYED _____

METHOD OF PAYMENT (CHECK ONE) \$65 CASH _____ \$65 CHECK _____ (MAKE CHECKS PAYABLE TO: "Smart Heart Scans")

The athlete named above is registering for an echocardiogram (echo), a common type of ultrasound that will allow physicians to view the heart. The purpose of this exam is to determine whether or not my son/daughter has a condition known as **Hypertrophic Cardiomyopathy (HCM)**, or enlarged heart - a primary cause of **Sudden Cardiac Death (SCD)** among young athletes. In the event my son/daughter will be detected to have HCM during this scanning, I will be notified and advised to see our primary care physician for follow-up care. No results will be given out the day of the screening.

This exam is being organized through the "Smart Heart Scans" for athletes program, made available by BESTT for U.S., Inc. – a 501 (c) (3) non-profit corporation. During the examination, a registered sonographer will image the heart of the athlete using a transducer placed on the chest. While the test itself should last approximately 10 minutes, please allow 30-minutes for your appointment. Student athletes will not receive any medications so, he/she will be able to drive himself/herself home after the test.

NOTE: The section below must be signed by the athlete’s parents or guardians before the echo can be administered.

The object of this echocardiogram is to ascertain whether or not my child has a condition called **Hypertrophic Cardiomyopathy** or **HCM**. **HCM** is a potentially life-threatening cardiac condition that may affect some adolescents. I understand that the “**Smart Heart Scans**” for athletes program is a special service to round out my son/daughter’s high school sports physical. I am aware that this exam does not replace a satisfactory physical evaluation by my primary care physician. In addition, I know that not all young athletes with **sudden cardiac death** have **HCM** and the sonographer, cardiologists and other parties involved in “**Smart Heart Scans**” for athletes **cannot** be held responsible for any sudden or unforeseen outcomes resulting from my child’s involvement in sports. I am willingly allowing my child to take part in the “**Smart Heart Scans**” for athletes program and have read, and am familiar with, the information provided to me relative to the Protected Health Information/Notice of Privacy Practices.

I have read the above information and give my consent for _____ to

(please print name of athlete)

undergo an echocardiogram administered by representatives of “Smart Heart Scans” for athletes. I understand that my child’s school, its staff and the county in which the school is located are not liable or accountable for the administration of the test or the interpretation of the results. (All parents or guardians must sign and date.)

Signature of Parent/Guardian Date

(Print Parent/Guardian Name Here)
