



Wednesday November 1, 2023,

9am-10am and 10:30am-11:30am

(GPHS bus transportation provided)

**Hosted by: Snohomish School District at
Snohomish HS Main Gymnasium**

1316 Fifth Street, Snohomish, WA 98290

**Appointments are open to anyone ages 12-24
regardless of where they go to school.**

**GPHS students ONLY will be bussed and
must pre-register for an appointment at the GPHS
athletic office, to receive forms to complete and
reserve bus transportation.**

**Questions call 360.563.7263 or email:
communications@sno.wednet.edu**

Nick of Time Foundation is providing
this EKG Youth Heart Screening at no
cost or obligation. However, to help defer
screening costs, and enable future
community screening events, there is a
suggested donation of \$25.00

Donations are tax deductible, and can be
made at time of registration, by cash, or
check payable to:

Nick of Time Foundation

Or by online donation at:

www.nickoftimefoundation.org/donate/

Nick of Time Foundation EKG Youth Heart Screening

Dear Parents and Coaches:

Sudden Cardiac Arrest is the leading cause of death in exercising or at play young people on school campus. Nick of Time Foundation in partnership with the UW Center for Sports Cardiology conducts EKG youth heart screenings for adolescents and young adults ages 12-24. Screenings consist of a Heart Health Survey asking about possible signs & symptoms or family history of a heart condition. An EKG is performed that analyzes the electrical signals of the heart and the results are reviewed on site by medical professionals experienced in EKG youth heart screens. A simple EKG can identify certain serious heart conditions that cannot be detected by a stethoscope.



NO ONE WILL BE SCREENED WITHOUT THE SIGNED FORMS LISTED BELOW

- 1. EKG Youth Heart Screening Permission Form and Waiver**
- 2. Participant Medical History Questionnaire**

What happens at a screening?

The screening is completely painless and non-invasive (*no needles or x-ray exposure*) and consists of:

1. Review of health history questionnaire
2. EKG screening (Small patches with a mild latex free adhesive will be placed on the chest, legs, and arms. Electrodes are attached to the patches and the heart's electrical activity is recorded)
3. "Hands only" instruction in CPR and AED training
4. Doctor consult & screening results review
5. Some participants may also have a heart sounds physical or limited echocardiogram (ultrasound) of their heart.

We want to assure you that participants' confidentiality, privacy, and individual modesty will be respected throughout all aspects of the program. All girls will be screened by female health professionals in an area separate from boys. Additional privacy is available upon request.



Thank you for making your student's heart health a priority and for being a part of our mission to save young lives from Sudden Cardiac Arrest (SCA).


Nick of Time Foundation

DO NOT PRINT OUT AND RETURN
THE FOLLOWING EKG HEART
SCREENING PERMISSION AND
HISTORY FORM ON FRONT AND
BACK.

FORM **MUST** BE PRINTED OUT
AND COMPLETED ON
TWO SEPARATE PAGES.

**REGISTER FOR A SCREENING
APPOINTMENT IN PERSON AND
RETURN FORMS TO THE
GLACIER PEAK HIGH SCHOOL
ATHLETIC OFFICE.**

EKG Heart Screening Permission and History

 **You must bring this signed form to the screening.**

NICK OF TIME FOUNDATION ID# PARTICIPANT'S LAST NAME FIRSTNAME

The Nick of Time Foundation is offering a heart screening program for students, athletes, and young adults age 14-24. The information obtained from participants will be reviewed by medical personnel at the event. The identity of the screening participants and information obtained in the screening program will remain confidential and available only to the Nick of Time Foundation and the physicians helping at the event.

The data collected related to your heart screen will be reviewed by medical personnel participating in our event 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 Heart Health Survey, will be reviewed by medical personnel and can be included in a research study. Medical personnel will provide you with a summary of the results of your screening and may recommend additional evaluation through follow-up with your physician or specialist.

By agreeing to participate in the program, if so indicated you give permission to The Nick of Time Foundation and medical personnel to provide your screening results to your physician or cardiologist, and you authorize your physician to share the results and diagnosis of any subsequent testing with The Nick of Time Foundation.

I hereby give my permission for images of my child and/or myself, captured during a youth heart screening through video, photo, or digital camera, to be used solely for the purposes of Nick of Time Foundation promotional material and publications and waive any rights of compensation or ownership thereto.

I acknowledge that I have read the above 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 above. I understand that The Nick of Time Foundation 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 The Nick of Time Foundation, all physicians, technicians, volunteers, and all other persons, entities, individuals, and organizations harmless and waive all subrogation rights against The Nick of Time Foundation and their directors, officers and volunteers as respects process and results of this EKG youth heart screening performed on this day.

The undersigned represent that they have carefully read and fully understand each and every term, condition, and paragraph of the provisions contained in this document.

Complete either the first or second consent box below.

| | | |
|---------------------------------------|-----------------------|----------------------------------|
| Participants Under 18 Consent: | | |
| PARENT/GUARDIAN NAME (PRINT) | PARENT/GUARDIAN EMAIL | PARENT/GUARDIAN TELEPHONE NUMBER |
| HOME ADDRESS | | |
| PARENT/GUARDIAN SIGNATURE | DATE | |
| Participants 18-24 Consent | | |
| EMAIL | TELEPHONE NUMBER | |
| HOME ADDRESS | | |
| SIGNATURE OF PARTICIPANT | DATE | |



Please complete the following questions regarding the individual being screened:

DEMOGRAPHICS

Date of Birth: _____

Age: _____

Gender: Male Female Other

Race: (check all that apply):

- White
- Black or African-American
- Asian
- Native American/Native Alaskan
- Native Hawaiian or Other Pacific Islander
- Other: please specify: _____

Ethnicity (check one)

- Hispanic or Latino
- Not Hispanic or Latino

1) Do you play on an organized sports team or compete in an individual sport? Yes No

If yes, what level?

- Club/Select
- Recreational/Intramural
- High School College Pro

2) Exercise and physical activity per week. On average I get... (check one)

- 5-10 hours of exercise or physical activity per week
- 2-5 hours of exercise or physical activity per week
- Less than 2 hours of exercise or physical activity per week

IF YES, what sport(s) do you play competitively or on an organized team? (Check all that apply)

- Baseball Martial arts
- Basketball Rowing
- Cheer Rugby
- X country Soccer
- Football Softball
- Field hockey Skiing
- Frisbee Swimming/Diving
- Golf Tennis
- Gymnastics Track
- Hockey Volleyball
- Lacrosse Wrestling
- Other: _____

PAST MEDICAL HISTORY

Do you have any ongoing medical conditions? Yes No

If yes, what illness? Asthma ADHD Diabetes

High blood pressure

Pre-existing heart condition _____

Other: _____

Are you taking any medication? Yes No

If yes, what medication? _____

Have you had a sports physical or well child evaluation by a physician or other medical provider within the last 12 months? Yes No

Have you been diagnosed with COVID-19? Yes No

If yes, when? Date: _____

| HEART HEALTH QUESTIONS | Student | | (If "Yes") After Physician Review | |
|---|---------|-----|-----------------------------------|-----|
| | No | Yes | No | Yes |
| 1. Have you ever passed out DURING exercise? (For example, while running or playing sport – not after) | | | | |
| 2. Do you get chest pain DURING exercise that makes you stop exercising? (For example, pain in the center or left side of your chest – not right side) | | | | |
| 3. Have you ever passed out or had a seizure suddenly and without warning in response to loud noises such as doorbells, alarm clocks, or ringing telephones? | | | | |
| 4. Has a close family member (parent, brother/sister, grandparent, aunt, or uncle) died from a heart problem or suffered sudden cardiac arrest before the age of 40? | | | | |
| 5. Does a family member have any of these genetic* heart conditions: <input type="checkbox"/> Hypertrophic cardiomyopathy (HCM) <input type="checkbox"/> Dilated cardiomyopathy (DCM) <input type="checkbox"/> Arrhythmogenic right ventricular cardiomyopathy (ARVC) <input type="checkbox"/> Marfans syndrome <input type="checkbox"/> Long QT syndrome (LQTS) <input type="checkbox"/> Catecholaminergic polymorphic ventricular tachycardia (CPVT) <input type="checkbox"/> Brugada syndrome *Does <u>not</u> include atrial fibrillation, congestive heart failure, coronary artery disease/heart attacks, or supraventricular tachycardia. | | | | |

Physician comments: _____

