

**INFORMED CONSENT
FOR PRE-PARTICIPATION CARDIOVASCULAR SCREENING**

Print Patient Name

REQUEST AND PERMISSION FOR CARDIOVASCULAR SCREENING

1. **Permission.** I hereby request and authorize Matthew J. Morahan Health Assessment Center for Athletes, and Barnabas Health and its and their employees, medical staff and agents to perform cardiovascular screening (the “Screening”) on me (or as applicable, my child). I understand that such Screening will involve the taking of an abbreviated medical history focused on cardiac health and performance of an EKG. On the basis of this Screening, I (my child) may be referred to specialists for additional testing. I also understand that there are other higher level screening tests that could be performed, such as echocardiograms and exercise testing, but will not be performed as part of the Screening, and I should discuss the need for higher level screening with my (my child’s) physician. I understand that in no event will I (my child) be treated for any condition, given a definitive diagnosis or given recommendations regarding continued participation in sports or athletic events solely on the basis of the Screening.
2. **Objectives of the Screening.** In a very limited number of occasions, individuals who participate in sports and athletic events have a specific risk factor(s) that make such individuals predisposed to a cardiac arrest and/or sudden death during, or immediately following such athletic activities (the “Specific Risk Factor”). I understand that the objective of the Screening is to evaluate whether I (my child) may require further cardiovascular testing or intervention to identify a Specific Risk Factor. I understand that the Screening is neither a comprehensive exam, nor a medical clearance for participation in such sports and athletic events, and I (my child) will not be evaluated for other conditions that are unrelated to my (my child’s) cardiac function. I understand that, regardless if I (my child) participate(s) in the Screening, I should consult with my (my child’s) physicians if I (my child) intend(s) to participate in any sports or athletic activities. Furthermore, if I have any concerns regarding my (my child’s) physical condition, I (my child) should seek additional medical evaluation and treatment.
3. **Inherent Risks.** I further understand that there are inherent risks in participating in sports and other athletic events and participation in the Screening will not reduce the inherent risks associated with sports or athletic events. Furthermore, the Screening does not reduce the risks associated with having a Specific Risk Factor, and therefore, even if the Screening leads to a referral, cardiac arrest or death could occur, whether or not participating in sports or other athletic events.
4. **Other Causes.** There are other possible causes of cardiac arrest and sudden death in athletes unrelated to the Specific Risk Factors, including, without limitation, use of illicit drugs, eating disorders and accidents. I understand that the Screening is not designed to identify all of the other causes of cardiac arrest or sudden death, and therefore, if any of these other causes occur or are present, I (my child) am (is) at risk for physical harm or injury, including sudden death, even though the Screening does not identify such issues. I understand that I should discuss these other causes with my (my child’s) physician who can provide advice regarding evaluation or treatment, as necessary.
5. **Explanation of Screening.** The procedure(s) involved in the Screening have been explained to me and I have been provided with the necessary information for me to evaluate the risks and benefits of the proposed Screening. I have also received information regarding: (a) the nature and purpose of the Screening; (b) alternatives to the Screening, as well as the relevant risks and benefits of such alternative procedures; (c) clinical outcome if I do not elect to have the Screening; (d) the potential benefits and possible risks, side effects and complications associated with the Screening; and (e) the likelihood of achieving the goals of Screening. I have been given an opportunity to ask questions and all my questions have been answered satisfactorily.
6. **No Guarantees.** I am aware that there are certain risks and hazards connected with any treatment or screening that may result in complications or other consequences. I also know that no one can predict with certainty the results of medical treatment or screening because the practice of medicine is not an exact science. I acknowledge that no guarantees or assurances have been made to me concerning my (my child’s) Screening. I understand that this Screening is only able to identify a certain limited number of Specific Risk Factors associated with cardiac conditions and that there are other symptoms and Specific Risk Factors that cannot be

identified by the Screening. Therefore, regardless of the results of the Screening, I am not guaranteed that I (my child) do (does) not have a Specific Risk Factor. I am aware that unforeseen Specific Risk Factors may develop after the Screening, particularly in adolescents, and if I (my child) am (is) in high school, I (my child) should have the Screening repeated at least every two years (and every 3-4 years for college-age individuals) or earlier if symptoms develop and/or manifest. I understand that during the course of the Screening, additional conditions may be identified (although there is no guarantee that each and every condition that is present will be identified).

7. **Understanding of this Form.** I confirm that I have read and understand the above and all the blank spaces have been completed prior to my signing. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction.

Patient/Relative
or Guardian:

Signature

Print Name

Date

If Signed By Other Than Patient please state relationship and authority to sign on behalf of patient: _____

Witness/Interpreter:

Signature

Print Name

Date

