



HEART HEALTH SURVEY

CONTACT INFORMATION

Student Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Home Phone: _____ Mobile Phone: _____

School Student Attends: _____

Parent/Guardian Name: _____

Parent/Guardian Email Address: _____

Parent/Guardian BEST Contact Phone Number: _____

Your email will be added to the KEVS Foundation, Inc. database for newsletters and event updates;

***We will not provide or sell your email address to third parties for marketing purposes.*

The KEVS Foundation is providing this Heart Screening at no cost or obligation. Donations are always appreciated, so that we will be able to continue to provide screenings, education and AED donations to make our communities Heart Safe.

We hope that you will take the time to visit our website at www.KEVSFoundation.com to learn more about us and what we do, as well as information on Sudden Cardiac Arrest in youth.

Please make sure to like us on Facebook and follow us on twitter.

Please complete the following questions regarding the individual being screened:

DEMOGRAPHICS

Age: _____

Gender: Male Female

Race/ethnicity: (check all that apply)

- African-American/Black
- Caucasian/White
- Hispanic/Latino
- Asian/Pacific Islander
- Native American
- Other: please specify: _____

SPORTS & PHYSICAL ACTIVITY

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 Professional

If yes, what sport(s) do you play? (Check all that apply)

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Golf | <input type="checkbox"/> Skiing |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Squash |
| <input type="checkbox"/> Cheer | <input type="checkbox"/> Hockey | <input type="checkbox"/> Swimming/Diving |
| <input type="checkbox"/> Cross Country | <input type="checkbox"/> Lacrosse | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Cycling | <input type="checkbox"/> Martial Arts | <input type="checkbox"/> Track |
| <input type="checkbox"/> Dance | <input type="checkbox"/> Rowing | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Football | <input type="checkbox"/> Rugby | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Field Hockey | <input type="checkbox"/> Soccer | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Frisbee | <input type="checkbox"/> Softball | |

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

- More than 10 hours of exercise or physical activity per week
- 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

PAST MEDICAL HISTORY

Do you have any ongoing medical illnesses? Yes No

If yes, what illness? Asthma ADHD Diabetes High Blood Pressure

Other _____

Are you taking any medication? Yes No

If yes, what medication? _____

HEART HEALTH QUESTIONS	Yes	No
1) Do you get chest pain when you exercise?		
2) Have you ever passed out during or immediately after exercise?		
3) Do you have difficulty breathing or unexplained fatigue during exercise that is new or getting worse?		
4) Does your heart ever race (suddenly beat fast) without good reason?		
5) Have you ever had a seizure?		
6) Have you ever been diagnosed with: (if yes, check all that apply) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart infection <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Another heart problem <input type="checkbox"/> Kawasaki Disease		
7) Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)?		
8) Has anyone in your family died from a heart problem before the age of 50?		
9) Has anyone in your family died suddenly for an unknown reason before the age of 50 including Sudden Infant Death Syndrome (SIDS), unexplained car accident, or drowning?		
10) Does anyone in your family have any of the following medical problems: (if yes, please circle) Hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic, Right ventricular cardiomyopathy (ARVC), long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia (CPVT), Brugada syndrome, or Marfan syndrome		



Student/Athlete Permission to Participate in Heart Screening

Date: May 12th, 2017 At: Hampshire Regional High School

City: Westhampton State: MA

I, _____ (Parent/Guardian) give my permission for

_____ (Student/Athlete) to have the Hampshire

Regional Nurse, Mary Phelon present during the physician consult at the

KEVS Foundation Heart Screening, being held May 12th, 2017.

Should a physician need to contact me regarding the above student during this event, I can be reached at _____ (Phone Number).

If there is an abnormality identified on the heart screening, we (KEVS Foundation) will contact you (the above signed parent/guardian) at the phone number you have provided above. Due to the limited nature of this heart-screening event, there are instances where it is essential that students/athletes/patients need to follow-up with their primary care physician or a pediatric cardiologist for ongoing treatment or further diagnostic testing. These follow-up plans will be discussed with you and will also be communicated to the school nurse, Mary Phelon.

_____ (Parent/Guardian)

(PRINT)

_____ (Parent/Guardian Signature)

_____ (Date)