Knoxville Pediatric Cardiology

Electrocardiogram (EKG/ECG) Screening

Required Demographics (Please Print)

Participant Name: _____ **Birth date:**____/____/____ **Age:** _____**Sex: M F School:**_____
(First) (Middle) (Last)

Mailing Address:

_____
City State Zip Code

Father: _____**Mother:**_____**Legal Guardian:** _____
(First) (Last) (First) (Last) (First) (Last)

Participants Primary Phone: (_____) _____-_____ **Participants Secondary Phone:** (_____) _____-_____

Participants Primary Care Physician: _____

(Above information will be used only for processing, mailing, and contacting individuals of results when indicated, we ask that you be as complete as possible)

I give my permission for my child to participate in the Knoxville Pediatric Cardiology Screening program that will be offered in addition to the Knoxville Orthopaedic Clinic pre participation physical exams being held on Saturday, April 28, 2012. This cardiology screening involves my child receiving an electrocardiogram (EKG or ECG) which is a non-invasive test that measures the electrical activity of the heart and can detect certain heart abnormalities that could lead to sudden cardiac death.

I understand that my child's participation in the Knoxville Pediatric Cardiology EKG Screening is intended to identify heart abnormalities which may affect their health during physical activities. I assume all risks associated with my child's participation in the EKG screening. All such risks being known and appreciated by me and having read this waiver any and all claims I may have for damages against Knoxville Pediatric Cardiology and any and all individuals associated with this screening, their heirs, representatives and successors and assignees for any and all injuries suffered by my child in connection with this screening even though that liability may arise out of the negligence or carelessness on the part of those named in this waiver.

I understand that Knoxville Pediatric Cardiology or participating high schools will make their best efforts to keep my child's health information confidential pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) its related rules and regulations and other state laws. In the event my child's EKG indicates that further evaluation is needed, Knoxville Pediatric Cardiology may contact me for additional information.

I acknowledge that I have read this permission form and waiver and understand the risks associated with my child's participation in the Knoxville Pediatric Cardiology EKG screenings.

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Agreement to participate in Electrocardiogram (EKG/ECG) Screening

Date: _____ Signature of Participant (If age 18 or older):_____

Date: _____ Signature of Parent/Guardian: _____ Parent/Guardian (Please Print):_____

(The below section reserved for KPC screening staff only)

Electrocardiogram performed by:_____