

Instructions: Please answer all questions on pages 1, 2, and 3 using black or blue pen only. Fill in circles completely. Do not make extra marks outside of the circle. If you make a mistake, cross out the wrong PRINTX and fill in the correct circle. Do not write in STAFF ONLY sections.

Participant Information

Print home ZIP code (example)

Age (Y) ☐ <10 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17
☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ >25

Sex at birth ☐ Male ☐ Female Hispanic/Latino ☐ Yes ☐ No

Race ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander
☐ Asian ☐ White/Caucasian
☐ Black or African American ☐ Other

Do you have an allergy to latex? ☐ Yes ☐ No ☐ Unsure

Please write in
your weight
and height in
the boxes
and fill in
corresponding
circles

**Weight
(lbs)**

☐ 1 ☐ 1 ☐ 1
☐ 2 ☐ 2 ☐ 2
☐ 3 ☐ 3 ☐ 3
☐ 4 ☐ 4
☐ 5 ☐ 5
☐ 6 ☐ 6
☐ 7 ☐ 7
☐ 8 ☐ 8
☐ 9 ☐ 9
☐ 0 ☐ 0 ☐ 0

**Height
(ft,in)**

☐ 3ft ☐ 1in
☐ 4ft ☐ 2in
☐ 5ft ☐ 3in
☐ 6ft ☐ 4in
☐ 5in
☐ 6in
☐ 7in
☐ 8in
☐ 9in
☐ 10in
☐ 11in

STAFF USE ONLY

SCREENING
SITE ZIP CODE

LAST
NAME

FIRST
NAME

PARTICIPANT ID CODES



NATIONAL PILOT STUDY SCREENING FORM Health Information

Have you had COVID? ☐ Yes ☐ No ☐ Unsure

If you had COVID, was it more or less than six months ago? ☐ <6mo ☐ >6mo ☐ Unsure

If you had COVID, were you hospitalized? ☐ Yes ☐ No ☐ N/A

If you had COVID, do you *currently* have any symptoms that you did not have *before* having COVID like chest pain, shortness of breath, or fatigue (very tired)? ☐ Yes ☐ No ☐ N/A

Do you have any ongoing medical illnesses? ☐ Yes ☐ No ☐ Unsure

Do you have asthma? ☐ Yes ☐ No ☐ Unsure

Do you have sickle cell disease or sickle trait? ☐ Yes ☐ No ☐ Unsure

Do you have a seizure disorder? ☐ Yes ☐ No ☐ Unsure

Please list any other medical problems (write only in box)

YYMMDD-SCGP_UUIDHEXX

Do you have any active heart problems? ☐ Yes ☐ No ☐ Unsure

Have you ever been told you have a heart murmur? ☐ Yes ☐ No ☐ Unsure

Have you been restricted from exercise due to a heart problem? ☐ Yes ☐ No ☐ Unsure

Have you ever had any of the following? (check all that apply)

- | | | |
|---|---|--|
| <input type="radio"/> Kawasaki Disease | <input type="radio"/> High blood pressure | <input type="radio"/> Long QT Syndrome |
| <input type="radio"/> Rheumatic Fever | <input type="radio"/> Congenital heart disease | <input type="radio"/> Cardiomyopathy (hypertrophic, dilated, or other) |
| <input type="radio"/> Myocarditis | <input type="radio"/> Heart rhythm problem | <input type="radio"/> Marfan Syndrome |
| <input type="radio"/> Cholesterol problem | <input type="radio"/> Wolff Parkinson White (WPW) | <input type="radio"/> Prior heart surgery |

Do you currently take any of these types of *medications or supplements*? (check all that apply)

- | | | |
|-------------------------------------|--------------------------------------|--|
| <input type="radio"/> Asthma | <input type="radio"/> Blood pressure | <input type="radio"/> Anxiety/Depression/Seizure |
| <input type="radio"/> Heart problem | <input type="radio"/> ADD/ADHD | <input type="radio"/> Energy drinks/supplements |

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NOTES



Health Information (continued)

Do you get chest pain with exercise?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Do you get tired more easily than others during exercise?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Do you get very short of breath with exercise (not asthma)?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Does your heart race or skip beats with exercise?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Does your heart race or skip beats when you are at rest?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Have you ever had a seizure?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Have you every passed out, or nearly passed out, during or right after exercise?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Any relative <40 years old die suddenly from a heart problem?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Any relative <40 years old survive a sudden cardiac arrest?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Any relative die from SIDS (Sudden Infant Death Syndrome)?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Any relative die from drowning or unexplained solo car accident?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure

Do you have any immediate family member or blood relative with any of the following?

- | | | |
|---|---|--|
| <input type="radio"/> Cardiomyopathy (HCM or other) | <input type="radio"/> Brugada Syndrome | <input type="radio"/> Abnormal Heart Rhythm |
| <input type="radio"/> ARVC | <input type="radio"/> CPVT | <input type="radio"/> Pacemaker or defibrillator |
| <input type="radio"/> Long QT Syndrome | <input type="radio"/> Wolff Parkinson White (WPW) | |

Do you play organized sports on a team? ☐ Yes ☐ No

- Check all levels of current sports**
- | | | |
|--|--|-----------------------------------|
| <input type="radio"/> Recreational | <input type="radio"/> High School Team | <input type="radio"/> Club/Select |
| <input type="radio"/> Middle School Team | <input type="radio"/> College Team | <input type="radio"/> Pro/Elite |

Do you exercise more than 4 hours per week? ☐ Yes ☐ No ☐ Unsure

Check all activities in which you spend more than 4 hours per week exercising:

- | | | | |
|-----------------------------------|-------------------------------------|----------------------------------|--|
| <input type="radio"/> Band | <input type="radio"/> Cross country | <input type="radio"/> Gymnastics | <input type="radio"/> Swimming |
| <input type="radio"/> Baseball | <input type="radio"/> Drill/ROTC | <input type="radio"/> Lacrosse | <input type="radio"/> Track/Field |
| <input type="radio"/> Basketball | <input type="radio"/> Field Hockey | <input type="radio"/> Other | <input type="radio"/> Volleyball |
| <input type="radio"/> Cheer/Dance | <input type="radio"/> Football | <input type="radio"/> Soccer | <input type="radio"/> Weightlifting |
| <input type="radio"/> Crew | <input type="radio"/> Gym/PE | <input type="radio"/> Softball | <input type="radio"/> Workout/Running/Aerobics |

STAFF
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NOTES

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Duke University is conducting an important study to follow individuals after heart screening. To participate, please check yes below and enter a cell phone number. You will receive a text message within one to three weeks which will guide you to the study site to register. After registering, you will be contacted one month and three months after the screening to answer simple questions about your heart health.

May we contact you to participate? >>>>>>>>>> ☐ Yes ☐ No

Is the number below for a parent/guardian? >>>>>> ☐ Yes ☐ No

Carefully print 10 digit cell phone number in box below
**(Example: enter (123) 456-7890 as

1	2	3
---	---	---

-

4	5	6
---	---	---

-

7	8	9	0
---	---	---	---

)**
***and* fill in the corresponding circle below each number**

The diagram illustrates a 10-bit ripple-carry adder. At the top, a 10-bit register holds the number -1, represented by a 1 in the 10th bit and 0s elsewhere. Below the register, a network of logic gates (AND, OR, XOR) implements the carry propagation logic. At the bottom, three 10-bit registers are shown, each containing the decimal digits 0 through 9, representing the possible outputs of the adder.

STAFF USE ONLY

Y Y M M D D - S C G P

U U I D H E X X

Physical Exam (Staff use only)

Murmur heard? ☐ Yes ☐ No ☐ Not assessed

Point of maximum impulse? ☐ Norm ☐ Abnl ☐ Not assessed

Marfan appearance/stigmata? ☐ Yes ☐ No ☐ Not assessed

Brachial/Femoral pulses? ☐ Norm ☐ Abnl ☐ Not assessed

Arm systolic blood pressure

- ☐ 1 ☐ 1 ☐ 1
☐ 2 ☐ 2 ☐ 2
☐ 3 ☐ 3
☐ 4 ☐ 4
☐ 5 ☐ 5
☐ 6 ☐ 6
☐ 7 ☐ 7
☐ 8 ☐ 8
☐ 9 ☐ 9
☐ 0 ☐ 0

Enter measured
height and weight
in either standard
or metric units

Height (cm)

- ☐ 1 ☐ 1 ☐ 1
☐ 2 ☐ 2 ☐ 2
☐ 3 ☐ 3
☐ 4 ☐ 4
☐ 5 ☐ 5
☐ 6 ☐ 6
☐ 7 ☐ 7
☐ 8 ☐ 8
☐ 9 ☐ 9
☐ 0 ☐ 0

Weight (kg)

- ☐ 1 ☐ 1 ☐ 1
☐ 2 ☐ 2 ☐ 2
☐ 3 ☐ 3
☐ 4 ☐ 4
☐ 5 ☐ 5
☐ 6 ☐ 6
☐ 7 ☐ 7
☐ 8 ☐ 8
☐ 9 ☐ 9
☐ 0 ☐ 0

Height (ft,in)

- ☐ 1in
☐ 2in
☐ 3in
☐ 4in
☐ 5in
☐ 6in
☐ 7in
☐ 8in
☐ 9in
☐ 10in
☐ 11in

Weight (lbs)

- ☐ 1 ☐ 1 ☐ 1
☐ 2 ☐ 2 ☐ 2
☐ 3 ☐ 3 ☐ 3
☐ 4 ☐ 4
☐ 5 ☐ 5
☐ 6 ☐ 6
☐ 7 ☐ 7
☐ 8 ☐ 8
☐ 9 ☐ 9
☐ 0 ☐ 0

STAFF USE ONLY NOTES





Screening Results (Staff use only)

Interpretation of history data: ☐ Normal ☐ Abnl ☐ Indeterminate

Interpretation of physical data: ☐ Normal ☐ Abnl ☐ Indeterminate

Was an ECG interpreted on site?

☐ Yes ☐ No

Was the ECG determined as normal or abnormal?

☐ Normal ☐ Abnl ☐ Indeterminate

What method was used to interpret the ECG?

☐ Provider interpretation ☐ Both
☐ International criteria

Select all reasons the ECG was abnormal:

☐ Arrhythmia ☐ Conduction abnormal (eg LBBB) ☐ WPW ☐ Other
☐ Voltages ☐ T waves ☐ QT interval

Who interpreted the ECG?

☐ Pediatric Cardiologist ☐ Pediatrician ☐ Other
☐ Adult Cardiologist ☐ Nurse Practitioner or Physician Asst.
☐ Family Medicine physician ☐ Sports Medicine physician

Was an echocardiogram performed on site?

☐ Yes ☐ No

Was the echo limited or full/complete?

☐ Limited ☐ Full

Was the echo normal or abnormal?

☐ Normal ☐ Abnl ☐ Indeterminate

Select all reasons the echo was abnormal:

☐ Ventricular function ☐ Coronary abnormality ☐ Ventricular dilatation
☐ Valve abnormality ☐ Hypertrophy ☐ Aorta abnormality

Who interpreted the echocardiogram?

☐ Pediatric Cardiologist ☐ Pediatrician ☐ Other
☐ Adult Cardiologist ☐ Nurse Practitioner or Physician Asst.
☐ Family Medicine physician ☐ Sports Medicine physician

Final Screening Result: ☐ Normal ☐ Abnormal ☐ Indeterminate

STAFF NOTES (scanned)



Cardiac Screening Permission And Waiver

Print name in **ALL CAPITAL** letters

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

SCREENING DATE

PARTICIPANT'S LAST NAME *(all capital letters)*

FIRST NAME

DATE OF BIRTH **must be age 12–25, no exceptions**

I, the undersigned, GIVE permission for my child (under 18 years old)/myself to voluntarily participate in the Eric Paredes Save a Life Foundation (The Foundation) cardiac screening (Cardiac Screening). A medical questionnaire will be reviewed, an electrocardiogram will be done and an echocardiogram may be performed at the Cardiac Screening. The Cardiac Screening will be conducted by independent health care personnel and other volunteers working together with the Foundation. The undersigned acknowledges and agrees that participation in the Cardiac Screening is completely voluntary and that it is the undersigned's decision to have my child/myself participate in this Cardiac Screening.

The information provided on the accompanying forms is, to the best of my knowledge, complete and correct. I understand and acknowledge that a finding of low risk from the limited screening being performed is not a guarantee of good health. Participation in this program cannot substitute for a consultation with a physician or other medical professional for any medical or health related condition or for regular physical examinations.

I understand and acknowledge that information received from this screening is to be considered preliminary only and does not constitute a diagnosis of my child's/myself health or physical condition. This is not a diagnostic study and is not intended to replace regular check ups with my child's/my physician. I further understand and acknowledge that I or another parent/guardian should discuss any abnormal results with my child's /my personal physician as soon as possible. I or another parent/guardian should ensure that any abnormal results from the Cardiac Screening are confirmed by a personal physician before any diagnosis or treatment is considered.

In order to have the Cardiac Screening performed on my child/myself and to participate in a screening, the undersigned, HEREBY RELEASES AND WAIVES ALL CLAIMS, ACTIONS, AND CAUSES OF ACTION that I or my child may otherwise have against the Eric Paredes Save A Life Foundation, the independent health care personnel and volunteers who are conducting or participating in this screening process, as well as and any vendors, sponsors, their officers, directors, employees, agents, volunteers, and representatives, from any claims, liability, or damages, including but not limited to personal injury or illness arising out of any physical, emotional, or mental injury or death that may occur in any way from my child/myself participation in this program resulting from the negligence, breach of warranty, or strict liability of any persons associated with the Cardiac Screening. The undersigned further agrees that neither the undersigned nor any of the undersigned's heirs, personal or legal representatives of family members will bring suit or make a claim for illness, injury, or death resulting from the Cardiac Screening and that this release is binding upon my heirs, legatees, administrators and personal representatives.

I understand that all of the medical information obtained through my child's/my participation in this program will be kept confidential and will not be retained or used by the screening facility. Once the results of the Cardiac Screening have been disclosed to the participant, and/or the parent(s), all of the medical information obtained will be de-identified via the removal of personally identifiable information. I give consent that the remaining anonymized data can be collected by the Eric Paredes Save A Life Foundation or its designees and that it may be used for medical and/or academic research purposes.

- ☐ Yes The Eric Paredes Save A Life Foundation may contact me to discuss the information obtained as a result of today's Cardiac Screening
- ☐ No I do not want to be contacted in the future about the information obtained as a result of today's Cardiac Screening

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	CITY	STATE ZIP
PARTICIPANT'S PEDIATRICIAN OR PRIMARY CARE PHYSICIAN	PHYSICIAN PHONE NUMBER	
PARENT/GUARDIAN SIGNATURE	DATE	

Participants 18–25 Consent:

NAME OF PARTICIPANT (PRINT)	EMAIL	PARTICIPANT PHONE NUMBER
HOME ADDRESS	CITY	STATE ZIP
PARTICIPANT'S SIGNATURE	DATE	

PARTICIPANT'S PRIMARY CARE PHYSICIAN	PHYSICIAN PHONE NUMBER
--------------------------------------	------------------------

FOR OFFICE USE

REVIEWED BY: _____

7

Medical Results

Print name in **ALL CAPITAL** letters

PARTICIPANT'S LAST NAME

FIRST NAME

SCREENING DATE

Dear Participant and/or Parent:

You were (or your child was) screened today during an event sponsored by the Eric Paredes Save a Life Foundation.

A screening is only a small window into the health and the well being of the heart. The American Heart Association recommends a heart screen be performed a minimum every two years. Please continue to monitor your heart health and contact your physician if you/your child develop any of these symptoms: shortness of breath, chest pain, heart palpitations, light headedness, or passing out.

Overall, your screening results today were:

- ☐ **Normal**—This includes your heart health history and ECG.
- ☐ **Normal after Echocardiogram**—This means something on your history and/or ECG suggested more testing was needed. An Echocardiogram was performed and was normal.
- ☐ **Normal screen but follow-up recommended**—All testing performed at the heart screen was normal, but something on your evaluation requires follow-up with a physician (see comments below).
- ☐ **Abnormal**—This indicates that something was abnormal on your history, ECG or Echocardiogram that requires additional testing and/or follow-up with your physician or a cardiologist (see comments below).
- ☐ Please contact your doctor to report the findings of this screening

Comments:

Thank you for your participation.

This screening does not substitute for a regular on-going relationship with a primary care physician, who is attuned to your medical history and any changes in health status. No screening can identify 100% of the individuals at risk for a sudden cardiac event.

We encourage you to continue to have yearly physicals and to discuss any concerns or changes in your health with your primary physician. If you have further questions about your child's/your health, please contact your physician.

Dr. John Rogers

After the screening, to request a digital copy of the ECG, go to epsavealife.org/contact and select the **red REQUEST ECG** button. Please note this non-profit foundation is staffed largely by volunteers. As such, please allow 14 days to receive results via email.

