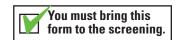
Cardiac Risk Assessment Questionnaire



CONFIDENTIAL

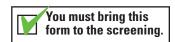
Please thoughtfully complete the form. Heart conditions are affected by a number of variables. Answering questions honestly will help doctors accurately assess your cardiac health.

Parents and youth under age 18 should complete the form together. Youth over 18 should consult their parent or family member for extended family heart history.

PARTICIPANT'S NAME (PRINT)			DATE OF BIRTH			
		☐ MALE ☐ FEMALE				
PARTICIPANT'S AGE		SEX AT BIRTH				
Race (check all that apply)						
	Dlack or African American	□ Nativa I	lavvaiian au	Daaifia lalamdan	□\\/hita □ Othar	
American Indian of Alaska Native Asian	Black or African American	□ INative i	awanan or	acilic islander (vvnite otner	
STAFF USE ONLY (will be taken at screening):	Blood Pressure	/				
PARTICIPANT'S MEDICAL AND SOCIAL HISTO	DRY					
Have you had COVID?		Yes	No	Unsure		
If so, were you hospitalized?		Yes	No			
Do you currently have any symptoms you did no	ot have before having COVID,					
like chest pain, shortness of breath or fatigue (v	ery tired)?	Yes	No			
Do you have any ongoing medical illness?		Yes	No			
Have you ever been diagnosed with asthma?		Yes	No			
Do you have sickle cell disease or sickle trait?		Yes	No			
Do you have any active heart problems?		Yes	No			
Have you been told you have a heart murmur?		Yes	No			
Have you been restricted from exercise due to a	a heart problem?	Yes	No			
Please list any other medical problems						
Have you ever had any of the following? (check	k all that apply)					
Kawasaki Disease	High blood pressure		Long	QT Syndrome		
Rheumatic Fever	Congenital heart disease		Cardi	omyopathy		
Myocarditis	Heart rhythm problem		☐ Marf	an Syndrome		
Cholesterol problem	Wolff Parkinson White (WP)	N)	☐ Prior	heart surgery		
Do you currently take any of these types of		apply)				
Asthma	Blood Pressure		Anxie Anxie	ety/Depression		
Heart problem	□ ADD/ADHD		☐ Seizu	re		



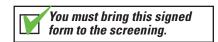
Cardiac Risk Assessment Questionnaire



Do you take any of the	• • •			_			
• .		If yes, how many per day/week?					
Performance enhancing supplements		If yes, how many pe					
☐ Diet pills		If yes, how many pe	er day/week	(?			
Do you get chest pain	or pressure?						
Resting	Walking	☐ Exercise	None				
Do you get tired more	easily than others?						
Resting	☐ Walking	☐ Exercise	None				
G	· ·		_				
Do you get very short Resting	Walking	ma)? Exercise	None				
	□ vvaiking	exercise					
Does your heart race							
Resting	☐ Walking	☐ Exercise	None				
Have you ever passed	d out, or nearly pass	sed out?					
Resting	Walking	☐ Exercise	None				
Have you ever felt ligh	nt-headed or dizzv?						
Resting	Walking	☐ Exercise	None				
	vvaliding	Excitates					
Have you ever had a sei	zure?			Yes	No		
Do you play a team sport?				Yes	No	Which Sport/s?	
Do you exercise more than 4 hours per week?				Yes	No		
PARTICIPANT'S FAMIL	Y HISTORY						
For questions about rela	ntives, please include	information about t	he participa	nt's exten	ded fa	amily,	
including siblings, parer	nts, aunts, uncles, cou	sins and grandpare	nts.				
Are you adopted?				Yes	No	Unsure	
Has any relative under a	age 40 developed hea	rt disease?		Yes	No	Unsure	
Has any relative under age 40 died suddenly from a heart problem?			m?	Yes	No	Unsure	
Has any relative under age 40 had a sudden cardiac arrest?			Yes	No	Unsure		
Has a relative died from SIDS (Sudden Infant Death Syndrome)?			Yes	No	Unsure		
Any unexplained or unex	xpected deaths for an	yone in your family	?	Yes	No	Unsure	
Any relative die from drowning or unexplained care accident?				Yes	No	Unsure	
Has any relative suffered from unexplained fainting or seizure?				Yes	No	Unsure	



Cardiac Screening Permission And Waiver



Print name in **ALL CAPITAL** letters

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 <u>independent health care personnel</u> 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	

By attending this event you hereby consent to the possibility of having your photo, likeness or video posted publicly and/or on social media. This is done in good taste with the intent of educating other families about the opportunity to get a preventative youth heart 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		EMAIL PARENT/GUARDIAN TELEPHONE NUMBER	
HOME ADDRESS	CITY	STATE Z	P		
PARENT/GUARDIAN SIGNATURE		DATE			
Participants 18–25 Consent:					

Participants 18–25 Consent:			
NAME OF PARTICIPANT (PRINT)	EMAIL		TELEPHONE NUMBER
HOME ADDRESS	CITY	STATE	ZIP
PARTICIPANT'S SIGNATURE		DATE	

	FOR OFFICE USE
PARTICIPANT'S PRIMARY CARE PHYSICIAN TELEPHONE NUMBER	REVIEWED BY: