Sullivan County Community Hospital
2200 North Section St.
Sullivan, IN 47882
Phone: 812-268-4311

Consent to Examination and Release of Liability

We, the undersigned, parent(s), guardian of ____
Student (please print)
Do hereby release all parties involved in providing the noninvasive single view parasternal long and short axis two dimensional screening echocardiogram from any liability associated with the performance of this examination. We (I) acknowledge that the results of this examination will identify a limited number but not all cardiac abnormalities that could result in sudden death. A copy of the test results will be provided to the school nurse as part of the physical record.

____ ___________________________
Parent/Guardian Signature Date

Please answer the following:	**Circle**
1. Have you ever passed out, fainted, or become dizzy during exercise?	Yes or No
2. Have you ever had chest pain during exercise?	Yes or No
3. Have you ever had high blood pressure?	Yes or No
4. Have you ever been told you have a heart murmur?	Yes or No
5. Have you ever had a very fast, racing heart beat or skipped beats?	Yes or No
6. Has anyone in your family ever died suddenly before the age of 55?	Yes or No
7. Has anyone in your family ever been diagnosed with Marfan's Syndrome?	Yes or No

____ ____
Name of School Family Physician

____
School Nurse (if known)

These questions should be answered before the athlete appears for the screening examination.

Call (812) 268-4311, ext. 2281, Monday-Friday, 8am to 4pm, to schedule the test with the Radiology Department.