Staten Island University Hospital
Northwell Health

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

Student Name: _____ Date of Birth: _____ Sex: ____

Parent/Guardian Phone: Home: _____ Cell: _____

Parent/Guardian Email: _____

Pediatrician: _____

Note: You'll be notified of results by phone or email. Please ensure that the information above is legible.

Question	Yes	No	Additional Info
Has the child ever fainted or passed out during exercise or physical activity?			
Has the child ever had chest pain, tightness, or pressure during exercise?			
Has the child experienced unexplained shortness of breath or fatigue during exercise?			
Has the child ever been diagnosed with a heart condition or had a heart murmur?			
Has the child ever had palpitations or irregular heartbeats, especially during exercise?			
Has anyone in the child's immediate family (parents, siblings) or extended family (grandparents, aunts/uncles) died suddenly or unexpectedly before the age of 50, including from heart-related issues or unexplained causes?			Relationship: / Age of death:
Is there a family history of heart conditions such as hypertrophic cardiomyopathy, long QT syndrome, or other genetic heart diseases?			Relationship: / Condition:
Has the child ever had an unexplained seizure?			
Has the child been restricted from sports or told to stop physical activity by a physician due to heart concerns?			

I understand that this electrocardiogram (EKG) and echocardiogram (cardiac ultrasound) screening is not a substitute for a complete cardiac examination. I have been advised of any risks and the benefits of the screening and all my questions have been answered to my satisfaction.

Signature of Parent/Guardian: _____ Date: _____

To be completed by Evaluator

Screening Result (Circle one): Normal Abnormal

Cardiologist Comments: _____

Cardiologist: RS

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Authorization To Be Audio/Visually Recorded

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____
Address Telephone Number

_____ _____ _____
City State Zip

_____
Email

1. Permission

I, _____, hereby give my consent to the taking or making of photographs, audio recordings, video recordings, films, and/or the use of my health information for publications, marketing, advertising or other promotional campaigns, clinical publications, quotations and/or media interviews of me or the above-named individual ("Recordings") by a Northwell Health personnel or contractors, news media organizations, or any other person or entity that may be designated or authorized by Northwell Health, for the purpose of creating educational, clinical, scientific, informational, advertising, promotional and/or medical materials.

___ Check here if the use or disclosure you are authorizing is limited to a specific purpose and state the purpose below

_____

2. Permitted Uses

I have freely consented to the use of such Recordings by Northwell Health personnel or contractors, or any other person or entity that may be designated or authorized by Northwell Health in any manner such parties desire with respect to all of the uses and disclosures described below which I have checked, editing these Recordings at their discretion, using and licensing others to use such Recordings in any manner of media whatsoever and incorporating these Recordings into film or video productions or otherwise.

If authorizing all uses and disclosures described immediately below, please check here:

_X__ All purposes specified below

If you wish to only authorize specific uses and disclosures, please check off all that apply:

___ Advertising Purposes
___ Brochures
___ Education, instructional or teaching purposes
___ Newsletters and Publicity

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___ Release to news media
___ Social Media (YouTube, Facebook, Twitter, etc.)
___ Northwell Health websites and Intranet
___ Other (please explain): _____

___ Fundraising publications
___ Commercial Television
___ Research

3. Identification

I understand, agree and consent that I, or the above-named individual, may be identified by name or other identifying characteristic in connection with any public use of this material.

4. Release from Liability

I do hereby release and hold harmless Northwell Health, its affiliated health care providers, Hofstra School of Medicine and each of their respective governing bodies, officers, agents, appointees, students, employees, and medical and nursing staff from any and all responsibility or for liability resulting from the taking or making of Recordings of me or the above-named individual by Northwell Health personnel or contractors, news media organizations, or any person, firm or organization that may be designated or authorized by Northwell Health, and any resulting release of private and personal medical, mental health and social information concerning me or the above-named individual and respective families. Northwell Health and its affiliated health care providers are not responsible for the release by third parties to whom it discloses information pursuant to this authorization.

5. Waiver of Royalties

I do hereby waive any and all rights I or the above-named individual may have to Recordings and royalties or other compensation in connection with the publication or other use of Recordings. I further acknowledge that there were no promises of any compensation for such use by Northwell Health and that Northwell Health exclusively owns all rights to these Recordings irrespective of the form in which they are produced and used.

6. Expiration Date or Event

This authorization will expire on (please check one and complete as applicable):

☐ One (1) Year
☐ Other (please specify expiration date) May 1, 2029

7. Revocation

I understand that I have the right to revoke this authorization at any time, except to the extent that Northwell Health or others have already taken action based upon the authorization. I hereby acknowledge that my revocation of this authorization will not prohibit the further disclosure of any Recordings by third parties who will have already received them based on this authorization. To revoke this authorization, please write to the **Northwell Health Department of Public Relations, 2000 Marcus Avenue, New Hyde Park, NY 11042.**

8. Voluntary Nature of Authorization

I understand this authorization is voluntary. Neither Northwell Health nor any health care providers with whom it is affiliated will condition medical treatment or other benefits on my willingness to sign this authorization.

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9. Redisclosure

I understand that persons or entities that receive Recordings under this authorization from Northwell Health may not be restricted from re-disclosing such Recordings under applicable law.

10. Signature

By signing below, I acknowledge that I have read and accept all of the above.

_____

Sign Name of Patient or Personal Representative (*individual authorized to consent to the use or disclosure of information)*
[Note: The consent of a parent or legal guardian is required if the subject of the Recordings is under 18 years of age or lacks the capacity to consent.]

_____

Print Name of Patient or Personal Representative (*individual authorized to consent to the use or disclosure of information)*

_____

Relationship to Individual

_____

Date

IF ANY HIV, GENETIC, SUBSTANCE ABUSE OR MENTAL HEALTH INFORMATION MAY BE INCLUDED IN ANY RECORDING MADE UNDER THIS AUTHORIZATION, THE INDIVIDUAL OR HIS OR HER PERSONAL REPRESENTATIVE MUST ALSO SIGN THE GENERAL NORTHWELL HEALTH AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FORM AND MUST SPECIFICALLY AUTHORIZE THE USE/DISCLOSURE OF THIS SENSITIVE HEALTH INFORMATION BY INITIALING THE APPLICABLE AREA(S) OF THE FORM.

THE INDIVIDUAL OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED. IF MAILING IN THE FORM, PLEASE RETAIN A COPY.

[For internal use only] Event/Purpose/Story: _____]