April 22, 2024

Dear Parents,

Sarah Bush Lincoln Health Center and the Rotary Athletic Heart Screening program is pleased to once again provide a *free* heart screen for high school athletes who will be between the ages of 15-17 years of age at the time of the screening. The screening will be on Saturday **November 2, 2024 from 8 a.m. - 12 noon** at SBL's Heart Center. This painless and harmless screening is intended to detect undiagnosed heart problems, which in the heat of competition could injure your child. It is not a complete cardiac work up.

This free service, which has been offered to athletes for many years, has detected heart abnormalities in a number of students. Although most abnormalities were minor, some have been quite significant and required treatment. I encourage you to allow your child to participate in this valuable program. If you have questions about the heart screen program, don't hesitate to contact me at the SBL Heart Center, **217-238-4550.**

This program includes collecting health history, performing a physical specifically targeted to detect at-risk athletes, and an electrocardiogram will detect dangerous electrical abnormalities of the heart. In addition, we are excited to offer, for the first time, a blood draw to check for iron deficiency!

Please complete the original Registration Form, Student Participation and Parental Approval form and History Worksheet. Forms cannot be copied due to the barcode feature on the forms. Be sure to fill out the original forms in detail and remember to sign them. **Forms must be returned to my office by Friday, October 18, 2024. Please make back to:**

**SBL Heart Center**
**ATTN: Lori Richardson**
**1000 Health Center Drive**
**Mattoon, IL 61938**
**Or email forms to: lrichardson@sblhs.org**

***What do you do after you return the form?*** Between 7:00 a.m.-3:00 p.m., October 21-25, 2024 call Lori Richardson in the Heart Center at **217-238-4550** to schedule an appointment for your child.

| | |
|---|---|
| October 18: | Forms due to SBL Heart Center via mail or email |
| October 21-25: | Parents call Lori to schedule November 4th screening |
| November 2: | Athletic Heart Screen Day |

For more information, visit http://www.sarahbush.org/rotary-heart-scan/. Thank you for your cooperation.

Sincerely,

Lori Richardson, MS RCEP

Lori Richardson
Clinic Supervisor – Heart Center
Sarah Bush Lincoln Health Center

**Rotary Athletic Heart Screening**
**November 2, 2024 Registration Form**

Name: ______________________________________________________________

Address: ____________________________________________________________

City: ___________________________ State: ________ Zip: ________________

Sex: ____________

Date of Birth: _____________________________

Name of School: _______________________________________________

**WE MUST HAVE THE INFORMATION LISTED BELOW**

Family Physician: ______________________________________________________

Physician Address: _____________________________________________________

City: ___________________________ State: ________ Zip: ________________

Name of Parents: ______________________________________________________

Address: ____________________________________________________________

City: ___________________________ State: ________ Zip: ________________

Home Phone: ____________________ Cell Phone: _________________________

Sarah Bush Lincoln

***NOTE: There are 3 forms with this packet that need to be completed and returned. If everything is not completed, we cannot schedule your child for this event.***

Name of Student (please print): ____________________

Name of School (please print): ____________________

The opportunity to participate in this limited cardiac screening program is entirely voluntary on my part.

Signature of Student ____________ Date ________ Time ________

I hereby give my consent for the above-named student to participate in a limited cardiac screening designed to identify undiagnosed abnormalities of the heart which could lead to sudden cardiac death in young athletes. The screening is offered free of charge and in good faith. I understand that the screening will be done at Sarah Bush Lincoln Health Center and results will be interpreted by a physician. If further testing is required due to abnormal test results, I understand that I am responsible for contacting my child's physician (listed below) concerning follow-up testing and I am responsible for the costs of those tests.

Name of Family Physician (please print): ____________________

Signature of Parent ____________ Date ________ Time ________

I give my permission to use a photograph or video of my son/daughter at the Rotary Athletic Heart Screening program for future publicity and marketing purposes.

Signature of Parent ____________ Date ________ Time ________



**ROTARY ATHLETIC HEART SCREENING
STUDENT PARTICIPATION and PARENTAL APPROVAL**

Sarah Bush Lincoln

Name: ______________________________ Age: _____

Ht: _____ Wt: _____ Sex: ☐ Male ☐ Female

School: ____________________ Sports: ____________________

____________________

____________________

____________________

**Health history:** (cardiac related) please check Yes or No for the questions below.

☐ Yes: ☐ No: Problems with heart / blood pressure?

☐ Yes: ☐ No: Chest pain with exercise?

☐ Yes: ☐ No: Dizziness or fainting with exercise?

☐ Yes: ☐ No: Any Surgeries? If yes, what kind:

________________________________________

________________________________________

________________________________________

**Family history:** (cardiac related) please check Yes or No for the question below.

☐ Yes: ☐ No: Has a family member died suddenly at less than 50 years of age of causes other than an accident?

________________________________________

________________________________________

________________________________________

______________________________ ______________

Signature Person Completing Form Date



**ROTARY ATHLETIC HEART SCREENING HISTORY WORKSHEET**