



Attached you will find most everything needed to participate in Kentucky High School Athletic Association (KHSAA) sanctioned sports at BishopCrossart this school year.

Some documents in this packet are for your family's information only, while others need to be completed and turned in PRIOR to your first practice. The information on participation fees and secondary insurance require no action. Everything else will be returned to the athletic office this year. A few helpful points:

- Physicals expire after 13 months. You must have a current physical on file to participate, including practice and tryouts.
- If you are unsure of your KHSAA physical status, please contact Mr. Verst at rverst@bishopcrossart.org
- To streamline paperwork, all forms in the packet should be turned in at the same time.
- If you have any questions or need additional copies of any paperwork, contact the athletic office.

All paperwork can be turned into the front office during office hours or placed in the drop box.



BBHS Athletic Participation Fees are paid at the time of each athlete's first participation.

High School Participation Fee:

\$180.00 - 1st Sport

\$90.00 - 2nd Sport

No Fee - 3rd Sport

Participation Fees for your 1st sport can be processed through your **FACTS** Tuition Account if you are on a monthly/quarterly payment plan. All one-time pay accounts will need to submit their payment to the school office.

Fees for the 2nd sport played will need to be paid by cash/check to the school office at the beginning of the sport season.

Questions: Call 635-2108

Middle School Participation Fee:

\$100.00 - 1st Sport

\$50.00 - 2nd Sport

No Fee - 3rd Sport

Please Include Cash or Check
for Middle School Participation Fee

Please Make Checks Payable To **BBHS**

BISHOP BROSSART HIGH SCHOOL

STUDENT ACCIDENT INSURANCE

Dear Parent/Guardian:

Bishop Brossart High School has purchased accident insurance for all students. The insurance plan provides benefits for accidental injury while attending assigned classes or during school sponsored and supervised activities.

The insurance plan provided by Bishop Brossart High School does not pay 100% of all medical and dental expenses (SEE LIMITATIONS). Please note that the insurance provided by Bishop Brossart High School is "secondary" to any other family insurance plans and will pay only the eligible medical expenses not payable by other insurance sources. Following is information outlining the benefits and limitations of the school purchased insurance plan.

BENEFITS

If accidental bodily injury occurs while participating in a school sponsored and supervised activity and requires treatment within 30 days from the original date of injury by a licensed Physician, or treatment in a legally constituted hospital, the insurance company will pay the reasonable and customary expenses for necessary medical, dental or hospital care provided within one year from the date of the injury up to the policy maximum amount for any one injury, which are not paid by other collectible insurance plans. The insured shall have free choice of a physician or hospital for treatment. If, however, an insured has other valid coverage through another insurance plan(s) and does not choose a physician or hospital through the other plan, we will pay benefits as if the other plan's guidelines had been followed. (SEE LIMITATIONS BELOW).

LIMITATIONS - - - \$25,000 Maximum Medical Benefit

Hospital Inpatient (Semi-private room)	• Inpatient miscellaneous charges (\$1,500 maximum)
Outpatient hospital charges- Non-surgical (\$250 maximum)	• Outpatient Hospital Surgical (\$1,000 maximum)
Physician's surgery/fracture care fees (U & C up to \$1,500 max)	• Physician's non-surgical visits or consultations (\$25/visit)
Physical Therapy (\$25/visit- \$125 maximum)	Dental (\$100 per tooth)
Ground Ambulance (\$75 per injury)	Motor Vehicle (\$500 per injury)
Orthopedic Appliance (\$75 per injury)	Diagnostic x-rays, MRI's, CAT Scans (\$300 per injury)
Drugstore Prescriptions (\$50 per injury)	Eyeglasses (\$50 per injury)

*U&C means Usual and Customary charges when compared with the charges made for similar services and supplies.

CLAIM PROCEDURE

Pick up a Claim Form from the school. The Claim Form must be completed in its entirety. Part A of the claim form must be completed by a school official and Part B must be completed by a parent or guardian. The date of the accident and detailed description are required to verify that the incident was school related.

You must indicate on the claim form, when submitting a claim, the name of your personal insurance company before benefits can be paid by this insurance plan. Failure to provide complete claim information will prolong payment of allowable benefits. Thank you for your cooperation with this program.

EXCLUSIONS ...THE POLICY DOES NOT COVER

1. Contact lenses or hearing aids; damage to other than whole, sound, natural teeth or to existing dental bridge, crowns, restorations, or braces; orthodontic procedures and services; drugs, injections, miscellaneous supplies and medications except while hospital confined.
2. Boils, athlete's foot, impetigo or similar skin infections, rashes, poisonous vegetation reactions, warts, blisters, calluses, cramps, muscle spasms, allergies or allergic reactions, ingrown nails, appendicitis, hernia of any kind, however caused; infections occurring other than as a result of such injury; detached retina; or psychiatric care.
3. Any form of illness, sickness or disease including but not limited to the following: Perthes Disease, Osgood-Schlatter's Disease, Osteomyelitis, Oseteochondritis, Osteogenesis Imperfecta, Slipped Capital Femoral Epiphysis, Thrombophlebitis, Hysterical Reactions, or similar conditions.
4. Any form of criminal or felonious assault or the insured's being engaged in an illegal occupation.
5. Services or treatment rendered as a part of the school service by a hospital, physician, or person employed or retained by the Sponsor, or by a person related to the Covered Person by blood or marriage.
6. Riding in or on, being struck by, being towed by, boarding or alighting from, or operating any motorized or engine driven vehicle; provided, however, that eligible medical expenses not collected from other valid coverage will be payable up to \$500.00 in the aggregate.
7. Intentionally self-inflicted injury. War or act of war.
8. Injuries sustained by a Covered Person hereunder for which benefits are payable under any Workmen's Compensation or Employer Liability Laws, or while engaging in activity for monetary gain from sources other than the school.
9. Aviation in any form except while the Covered Person is riding as a passenger in a licensed airplane provided by an incorporated passenger carrier on a regularly scheduled passenger flight and route.
10. Riding in or on, being struck by, being towed by, boarding or alighting from, or operating any snowmobile or two or three wheeled motor vehicle.
11. The use of or while under the influence of drugs or intoxicants unless administered as prescribed by a physician.
12. The existence or aggravation of physical or mental infirmity, condition or disease, whether infectious, congenital, secondary or acquired in origin. Conditions or the aggravation of conditions that originated prior to the insured persons coverage under the policy.
13. Expense resulting from participating in activities for which benefits would be payable, in the absence of this insurance, under any high school or association catastrophe sports accident policy is expressly excluded under the policy.

PLEASE READ CAREFULLY:

You must indicate on the claim form the name of your personal insurance company and your policy number before benefits can be paid by the insurance plan. Failure to provide complete claim information will prolong payment of allowable benefits. **RETAIN THIS DESCRIPTION OF COVERAGE FOR YOUR RECORDS.**



AUTHORIZATION FOR TREATMENT & RELEASE OF HEALTH INFORMATION

As (please specify) parent/guardian of _____ (the "Student"), a student at _____ School (the "School") in _____, Kentucky, who desires to participate in extracurricular athletic program(s) of the School (the "Program"), I understand that in the course of competing in the Program or Program-sponsored events the Student may require attention or assistance from an athletic trainer for illness or injury incurred while participating in such Program-sponsored sporting events. I understand that the School has arranged for St. Elizabeth Healthcare to provide such attention and assistance during certain Program-sponsored events and I authorize Student to receive such attention and assistance. I, the undersigned, hereby authorize St. Elizabeth Healthcare to release all necessary medical information about the Student obtained in the course of providing athletic training attention or assistance during Program-sponsored events to the School and its representatives including, but not limited to, coaches, athletic director, team and/or family physician, for the purpose of making determinations regarding the continued participation of the Student in the Program or Program-sponsored sporting events.

I understand that I have the right to revoke this authorization at any time except to the extent St. Elizabeth Healthcare has already acted as a result of this authorization. I further understand that any revocation must be provided in writing to St. Elizabeth Healthcare.

I also understand that when information is used or disclosed based on an authorization, the information may be re-disclosed by the recipient and no longer protected by the Standards for the Privacy of Individually Identifiable Health Information.

This authorization shall expire at the end of the Program's season.

I understand that I have the right to refuse to sign this authorization.

Student's Name

Street/box number

Student's Date of Birth

City, State, Zip Code

Student's Signature (required if student is 18 or over or will turn 18 before program ends)

Student's Telephone Number

Name of Parent or Guardian

Date

Signature of Parent or Guardian

Relationship to Student (Parent, Guardian, etc.)



**Athletic Participation Form
Parental and Student Consent and Release
For High School Level (grades 9-12) participation**

*KHSAA Form GE04
High School Parental Permission and Consent
Rev. 7/23, page 1 of 4
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*The student and parents/guardian must read this statement carefully and sign where required. By signing this form, all parties agree that they have accurately completed all sections of the form and have read and agree to the terms of this form as detailed. This form **must** be completed before the student participates (hereinafter including try out for, practice and/or compete) in interscholastic athletics. This form should be kept in a secure location until the student has exhausted eligibility, graduated from high school and reached the age of 19. Any use of additional optional supplemental forms such as the PPE01 to gather medical information from both the family and the medical community is to be kept separate from this form and maintained in compliance with state and federal privacy laws.*

ATHLETE INFORMATION (This part must be completed by the student and family)

Name (Last, First, Initial) _____ School Year _____

Home Address (Street, City, State, Zip): _____

Gender _____ Grade _____ School _____

Date of Birth: _____ Birth Place (County, State): _____

School Attendance History

Grade	School Name	School Year	Varsity Play – (Yes/No)?
9			
10			
11			
12			

I am planning to participate in the following (check all you might try to play):

- | | | | | |
|---------------------------------------|--|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Archery | <input type="checkbox"/> Bowling | <input type="checkbox"/> Esports | <input type="checkbox"/> Soccer | <input type="checkbox"/> Track and Field |
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Competitive Cheer | <input type="checkbox"/> Football | <input type="checkbox"/> Softball | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Golf | <input type="checkbox"/> Swimming | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Bass Fishing | <input type="checkbox"/> Dance | <input type="checkbox"/> Lacrosse | <input type="checkbox"/> Tennis | <input type="checkbox"/> Other _____ |

EMERGENCY CONTACT INFORMATION

_____ Name (please print) _____ Relation to Student _____

_____ Emergency Contact Address, including City, State and Zip _____

_____ Daytime Phone _____ Cell Phone _____

CONSENT INFORMATION TO PARTICIPATE, ACKNOWLEDGMENT OF RISK, ACKNOWLEDGEMENT OF ELIGIBILITY RULES, LIABILITY WAIVER AND CONSENT AND RELEASE

As parent/legal guardian, I agree to allow my child to participate in interscholastic athletics.

The student and parent/legal guardian recognize that participation in interscholastic athletics involves some inherent risks for potentially severe injuries, including but not limited to death, serious neck, head and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to internal organs, serious injury to bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of the body, or effects to the general health and well being of the child. Because of these inherent risks, the student and parent/legal guardian recognize the importance of the student following coaches' instructions regarding playing techniques, training and other team rules. By signing this form, the student and parent/legal guardian acknowledge that the student's participation is wholly voluntary and to having read and understood this provision.

The student and parent/legal guardian individually and on behalf of the student, hereby irrevocably, and unconditionally release, acquit, and forever discharge the KHSAA and its officers, agents, attorneys, representatives and employees (collectively, the "Releasees") from any and all losses, claims, demands, actions and causes of action, obligations, damages, and costs or expenses of any nature (including attorney's fees) that the student and/or parent/legal guardian incur or sustain to person, property or both, which arise out of, result from, occur during or are otherwise connected with the student's participation in interscholastic athletics if due to the ordinary negligence of the Releasees.

The student and parent/legal guardian, individually and on behalf of this student, consent to the high school and the KHSAA and their representatives to use and disclose the necessary personally identifiable information from the student's education records including academic, financial and health care information, to third parties including school representatives, coaches, athletic trainers, medical facilities, medical staffs, KHSAA legal counsel and the media, for the purpose of receiving proper/necessary medical care and complying with the KHSAA bylaws, including making determinations regarding eligibility to participate in interscholastic athletics and any administrative or legal proceedings resulting from participation or attempted participation in interscholastic athletics, without such disclosure constituting a violation of rights under the Family Educational Rights and Privacy Act. The student and parent/legal guardian, individually and on behalf of this student, further release the high school, the KHSAA and their representatives from any and all claims arising out of the use and disclosure of said necessary personally identifiable information, and agree to release to the high school, the KHSAA, and their representatives, upon request, the detailed and completed application for financial aid.



**Athletic Participation Form
Parental and Student Consent and Release
For High School Level (grades 9-12) participation**

*KHSAA Form GE04
High School Parental Permission and Consent
Rev. 7/23, page 2 of 4
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The student and parent/legal guardian, individually and on behalf of this student, give the high school, the KHSAA and the authorized representatives of the KHSAA permission to release this student's demographic information (including motion picture and still photographic images) and participation statistics (including height, weight and year in school, participation history and other performance based statistics) and other information as may be requested or presented. The student and parent/legal guardian, individually and on behalf of this student, agree that the student may be photographed or otherwise digitally or electronically captured during school-based competition and such product used in the course of normal KHSAA business including commercial and internet-based video and still images. All of this material may be used without permission or compensation specifically related to the KHSAA and its events, without such use constituting a violation of rights under the Family Educational Rights and Privacy Act.

The student and parent/legal guardian, individually and on behalf of the student, hereby acknowledge that they are aware of and will review if desired, the education materials available through the KHSAA, the Centers for Disease Control and other agencies regarding education all individuals with respect to nature and risk of concussion, head injury, or other ongoing health concerns, including the continuance of play after concussion or head injury.

The student and parent/legal guardian consent to this student receiving a physical examination from an authorized medical provider as required by the KHSAA.

The student and parent/legal guardian, individual and on behalf of the student, hereby consent to allow the student to receive medical treatment that may be deemed advisable by the school, the KHSAA, and their representatives in the event of injury, accident or illness while participating in interscholastic athletics, including, but not limited to, transportation of the student to a medical facility. The student and parent/legal guardian, acknowledge that transportation to a medical facility may involve having to provide the student's birthday and social security number solely for potential hospitalization and emergency care needs and is not required to be recorded on this form. However, those failing to provide this information should be aware that this might be required by emergency treatment facilities prior to rendering service, and failure to provide could result in lack of appropriate care.

The student and parent/legal guardian acknowledge that they have read and understood the KHSAA Bylaws by distribution under the handbook links at <https://khsaa.org/>. Please be aware that a student is subject to the one-year period of ineligibility per the bylaw commonly referred to as the "Bylaw 6, Transfer Rule," upon participation in any varsity contest after enrolling in grade nine regardless of the amount of participation or lack thereof.

The student and parent/legal guardian agree to abide by the KHSAA Bylaws and Due Process Procedure as now enacted or later amended. The student and parent/legal guardian further acknowledge that they agree to abide by the rulings of the Commissioner, Assistant Commissioner, Hearing Officer and Board of Control.

The student and parent/legal guardian acknowledge that per the appropriate bylaw, the student must have medical insurance coverage up to a limit of \$25,000 in order to be eligible to participate in interscholastic athletics.

REQUIRED INSURANCE INFORMATION (KHSAA Bylaw 12)

Prior to participation in practice or contests (including trying for a place on a team) in any sport or sport activity during the limitation of seasons as defined in Bylaw 23, all students are required to have medical insurance with coverage limits of at least \$25,000. If this coverage is provided through the school, contact the Principal or Athletic Director regarding any potential claim. Individual schools and districts may impose additional requirements for insurance or coverage during additional periods for activities outside of Bylaw 23.

Insurance Carrier	Policy Number / ID Number	Group Number	Plan
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STUDENT AND PARENT/GUARDIAN ACKNOWLEDGMENT OF RISK, ELIGIBILITY RULES, LIABILITY WAIVER AND CONSENT AND RELEASE AND EMERGENCY PERMISSION FORM

Students' Name (please print)	School
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Student and Parent/Guardian Address including City, State and Zip

Signature of Student	Date
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Please list above any health problems/concerns this student may have, including allergies (medications / others) and any medications presently being used

Name of Parent(s)/Guardian(s) who has/have custody of this student (please print)	Emergency Phone Number
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Signature of Parent(s)/Guardian(s) who has/have custody of this student	Date
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■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

- Medically eligible for certain sports

- Not medically eligible pending further evaluation

- Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA
or DC (if within scope of practice)

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

THIS PAGE IS TO ENSURE THAT THE GE04 IS DISTRIBUTED AS NEEDED TO GIVE PERMISSION FOR MEDICAL TREATMENT. THE GE04 FORM SHOULD BE KEPT ON FILE UNTIL ONE YEAR AFTER THE STUDENT GRADUATES. THE GE04 FORM ONLY MAY BE USED TO TRAVEL WITH THE TEAM IN THE EVENT OF AN EMERGENCY.

HOWEVER IF THE OPTIONAL PPE01 FORM IS USED IN ANY WAY, THE THREE PAGES OF THAT FORM ARE NOT TO BE KEPT WITH THE GE04 AND SHOULD NOT BE HELD AT THE SCHOOL. PER STATE AND FEDERAL PRIVACY LAWS, THIS IS CONFIDENTIAL COMMUNICATION BETWEEN MEDICAL PROVIDER AND PATIENT AND SECURITY OF THIS INFORMATION IS PROTECTED BY A SERIES OF LAWS AND SHOULD REMAIN WITH THE FAMILY AND THE MEDICAL PROVIDER.

PER GUIDANCE FROM AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF SPORTS MEDICINE, AMERICAN MEDICAL SOCIETY FOR SPORTS MEDICINE, AMERICAN ORTHOPAEDIC SOCIETY FOR SPORTS MEDICINE, AND AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE, THE CONTENTS OF THE OPTIONAL PPE01 TO BE KEPT IN THE STRICTEST OF PRIVACY IN COMPLIANCE APPLICABLE LAWS.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM (FOR COMPLETION ASSISTED OR UNASSISTED BY STUDENT AND PARENTS)

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex at birth (F, M): _____

Have you had COVID-19? (check one): Y N

Have you been immunized for COVID-19? (check one): Y N If yes, have you had: One shot Two shots
 Three shots Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)
 Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No	
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			
10. Have you ever had a seizure?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

This form should be placed into the athlete's medical file and should not be shared with schools or sports organizations.

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ (_____ / _____)	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____

Address: _____

Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA