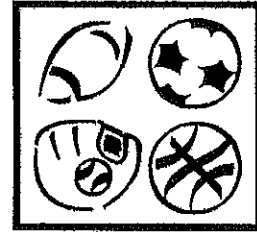


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**T • O • P • S**



team osteopathic  
physicals for students

Upcoming School Name \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

**CARDIOVASCULAR**

Family History Yes- No \_\_\_\_\_

Personal History Yes-No \_\_\_\_\_

EKG \_\_\_\_\_

ECHO NEEDED \_\_\_\_\_ ECHO DONE \_\_\_\_\_ NORMAL \_\_\_\_\_ ABNORMAL \_\_\_\_\_

ECHO FINDINGS \_\_\_\_\_

\*I understand and give permission for my child to have a free sports screening with an EKG and ECHO (if necessary). This information may be used for medical research (no names would be mentioned).

\*I hereby authorize TOPS (Team of Physicians for Students) to publish the photographs taken of me or my child, and my/his/her name, for use in the TOPS' printed publications and website.

I acknowledge that since my participation in publications and websites produced by TOPS is voluntary, I will receive no financial compensation.

I further agree that my participation in any publication and website produced by TOPS confers upon me no rights of ownership whatsoever. I release TOPS, its contractors and its employees from liability for any claims by me or any third party in connection with my participation.

Signature of Parent/Guardian/ Student if over 18 \_\_\_\_\_