HEALTH FAIR SCREENING
REGISTRATION, CONSENT, AND WAIVER OF LIABILITY

REGISTRATION

Name:____ Date of Birth:_______________

First, Middle Initial, Last Name

Mailing Address:____

Home Phone Number:________________ Cell Phone Number:_______________ Gender: M/F

Are you under a health care provider's care (physician, nurse practitioner, physician assistant, etc.)?
____Yes ____No
If marked "Yes," please check your health care provider's name.
___Dr. Licke ____Tyler Raile ___Kristle Raile

____Other______________

CONSENT TO HEALTH SCREENING AND WAIVER OF LIABILITY

1. Consent to Participate. I acknowledge and agree that I am voluntarily participating in Hospital's heath fair screening. *My involvement is as a participant and not as a patient*. I further acknowledge and understand that the screening is limited in nature and is not a substitute for seeking medical treatment or follow up with a health care provider.

2. Types of Screenings. I acknowledge and understand that the health fair is offering the following screenings:

   ______ Hepatitis C Testing - **$40 (extra)**

   ____All- (CMP; Lipid Profile; Thyroid test; CBC and Hemoglobin A1C Diabetes, a Pulmonary Lung Function screening and a PSA for men.
   If I marked "All," I am providing my consent to participate in all screenings offered at the health fair.

3. Consent for Blood/Body Fluid Testing; Risks. I acknowledge and understand that by participating in the health screening, I will be required to submit to blood and/or body fluid testing. I understand that I may experience slight pain or a bruise at the puncture site. There is also the risk of an accidental needle puncture or other biohazard exposure. In such a case, I authorize additional precautionary testing of the sample.

4. No Health Care Provider/Patient Relationship. With respect to my participation in the health screening, I acknowledge and understand that the health care provider is not my personal health care provider and is offering the screenings, recommendations, and self-care solely for my educational purposes. I understand that this means that I do not have a health care provider/patient relationship for purposes of the results of the screenings and I must contact my personal health care provider if I have additional questions or require follow up after the health fair.

5. Preliminary Results. I further acknowledge and understand that the screening results provided to me at the health fair are preliminary in nature and are in no way conclusive. I further understand that the screening is not diagnostic and it could fail to detect certain abnormalities that might be detected by more definitive screenings; or it might detect apparent abnormalities that would be found normal with more conclusive testing. For a conclusive medical diagnosis of any medical condition I may have, I understand that I need to be examined by my personal health care provider.

6. No Guarantees; Recommendations. The Hospital, its employees, agents, officers, members, and health fair participating health care providers make no claims, representations, or guarantees with respect to the accuracy or precision of screenings due to the limited nature of the evaluation provided. I acknowledge and understand that it is my sole responsibility to follow up on any recommendations that are made to me during the screening and obtain follow up evaluation, testing, and medical diagnosis from my personal health care provider.

7. Confidentiality. I understand that the Hospital will maintain the confidentiality of the screening results in accordance with the Hospital's ***Notice of Privacy Practices for Health Fair*** and applicable state and federal laws.

   ____ Initials I acknowledge that I have received a copy of the Hospital's ***Notice of Privacy Practices for Health Fair***.

8. Waiver and Release of Liability. In exchange for being given free or low-cost health screenings, I release, discharge, and hold harmless, the Hospital, its employees, agents, officers, members, and health fair participating health care providers from any and all claims, demands, losses, damages, or injuries, arising from, or based in whole or in part on, my participation in the Hospital's health fair, including, but not limited to, the results of the health fair screenings; any statements made to me by any health fair/lab agent, employee, or volunteer; nondisclosure to me of any information; or my receipt or non-receipt of any information from the health fair.

HEALTH FAIR PARTICIPANT ACKNOWLEDGMENT: I have read this form, or have had it read to me, and understand the contents of this form. I believe that I have the knowledge upon which to base consent to participate in the Hospital's health fair. All questions have been answered to my satisfaction. I hereby give consent to the screenings indicated above.

______________________________	______________________________
Health Fair Participant	Date
______________________________	______________________________
Witness	Date