2017 WELLNESS FAIR REGISTRATION

Time Requested
____
Time Assigned
____

Name: ____ Birth Date: ___________________________

Mailing Address: ____

Phone: ______________________________ Email: ____

Primary Medical Provider or "None":____

Name of Clinic: ____

Location and Phone: ____

Have you seen your Primary Medical Provider in the last 3 yrs.: Yes_______ No________

Ethnicity: ____Hispanic/Latino ____Non-Hispanic/Latino

Mark one age group: ___0-12 ___13-17 ___18-64 ___65 and older

Race: ____ White ____American Indian/Alaskan Native ____Asian Indian ____Black or African American

____Native Hawaiian/ Pacific Islander ____Asian ____More than one race ____ Unknown

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***NOTE**: Blood glucose, cholesterol, and skin cancer screenings will be performed by Syringa Hospital staff. You may be contacted by a staff member with your results.*

All other tests will be conducted by Community Health Workers (CHW) as part of a collaborative project funded by a grant and coordinated by St. Mary's/Clearwater Valley Hospitals. You may be contacted about the results of these additional tests by a member of their organization.

Consent and Release

I agree and request that health checks be performed for me by the healthcare providers participating in the SHC Wellness Fair.
I release and agree not to hold Syringa Hospital & Clinics and its participating organizations liable in connection with health checks and the Wellness Fair. This includes, but not limited to, anything committed or omitted by any of the participating organizations, their employees or other representatives, which may arise, and/or from any distributed information, and/or educational services performed.
I also agree to indemnify the SHC Wellness Fair and its participating organizations from any loss or claim made against them by me or someone on my behalf due to my participation in the SHC Wellness Fair. This indemnification will include all reasonable costs of the investigation and defense, including reasonable attorney fees. I understand that data derived from the health checks is to be considered preliminary and not conclusive; I, not the participating organizations, am responsible for initiating any follow-up examinations for abnormalities identified at the SHC Wellness Fair; not all health checks will be conducted by doctors or nurses; the health checks provided me are not comprehensive and should not take the place of regularly scheduled medical examinations. If there are specific medical complaints on my part, I should consult my personal provider regardless of the health check results.

Date: September 30, 2017 ____

E- Signature of Participant

Clearwater Valley Hospital and Clinics | Orofino, Idaho

St. Mary's Hospital and Clinics | Cottonwood, Idaho

Public Health Idaho North Central District

SYRINGA HOSPITAL & CLINICS

September 30, 2017 Syringa Hospital & Clinics Wellness Fair CHW:_______________________

GRANGEVILLE HUMAN NEEDS COUNCIL

Name:____

I agree that with my signature on the previous page I am releasing the CHW to perform one of the following: (Mark the option you choose.)

- ☐ Perform all screening tests marked below and report to the Primary Medical Provider indicated then follow up with me utilizing the info provided.
- ☐ Perform all screening tests and refer me to ___________________________clinic, location___________________, and then follow up with me utilizing the info provided.
- ☐ Perform all screening tests and provide me with the results but please do not provide info to my Primary Medical Provider.

Perform only the following screening tests marked below:

A1C: ___ BMI: ___ B/P: ___ Mood Score: ___ FIT Test Given? Yes_____ No_____

Insurance: (circle one) YES NO **Referral Made Benefits Counselor** (circle one) YES NO

RESULTS

***B/P: _____________ A1C: __________ BMI: ___________ Mood Score: __________**

*If you get a blood pressure reading of 180 or higher on top or 110 or higher on the bottom, and are having any symptoms of possible organ damage (chest pain, shortness of breath, back pain, numbness/weakness, change in vision, difficulty speaking) do not wait to see if your pressure comes down on its own. Seek emergency medical assistance immediately. If you can't access the emergency medical services (EMS), have someone drive you to the hospital right away. Instructions from the American Heart Association.

Referred to ____ CHW __________

Notes:____

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PARTNERSHIP

FOR HEALTHY COMMUNITIES