NECF

Name (print) _____ Date of Birth _____

Phone Number _____ ☐ Male ☐ Female ☐ Other

Address _____ City _____ State _____ Zip _____

Primary Care Physician/Provider (name and address) _____

I acknowledge that I am voluntarily participating in a health screening sponsored by this facility and herein request and consent to the performance of diagnostic studies and examinations. I understand that the information derived from my participation is not a complete health examination, but it will provide certain information that needs to be further evaluated by my physician. I certify that all of the information I have provided, or will provide, as part of said participation is true, correct, and complete to the best of my knowledge. I understand that the facility and the individuals providing the testing services undertake no obligation to follow-up or provide continuous services to me. I understand and accept the responsibility to follow up with my physician regarding the interpretation of these studies and examinations.

I consent to the following services to be performed today:

- ☐ Lipid profile (group of tests that check for the risk of coronary heart disease)
- ☐ Blood sugar (a test done to measure the level of glucose in my blood to check for diabetes)
- ☐ Cholesterol (measures the lipoprotein cholesterol in my blood)
- ☐ Fecal occult blood (tests a sample of my feces/stool for blood)
- ☐ Osteoporosis (bone density test)
- ☐ Body Mass Index
- ☐ Depression Screening
- ☐ Height
- ☐ Weight
- ☐ Vital signs (blood pressure, pulse, temperature, respirations and/or oxygen in my blood)
- ☐ Vision screening (eye chart only)
- ☒ Other Sports physical screening
- ☐ Other _____
- ☐ Other _____

I understand there are risks associated with health screenings, drawing blood or giving vaccinations, which include, but not limited to bleeding into the surrounding tissue, injury to the nerves at or near the site, or infection. X-Ray/imaging procedures carry the risk of radiation exposure, which in most examinations is very small. I understand I should not undergo any X-Ray/imaging procedures if I am pregnant without the written consent of my physician.

I attest: ☐ I am, or could be, pregnant. ☐ I am not pregnant. ☒ N/A

I agree for myself, my heirs, executors and administrators, to not sue and to release, indemnify and hold harmless Northeast Regional Medical Center and their affiliates, officers, managers, directors, volunteers, and employees from any and all liability, claims, demands, and causes of action whatsoever, arising out of my participation, whether it results from the negligence of any of the above or from any other cause. This release and indemnification shall be as broad and inclusive as is permitted by the State of Missouri. If any portion is held invalid, the balance shall continue in full force and effect.

Patient's Signature or Legal Representative	Date	Time

Relationship to Patient	Interpreter, if Utilized	Date	Time

Witness Signature	Date	Time	If Telephone Consent, Second Witness' Signature	Date	Time

Consent Health Screening
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(Rev. 04/10, 01/11, 05/15, 06/19, 09/21, 03/23)
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Patient Label