Summit Health™
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# Consent for Administration of Wellness Screening Tests

## Participant Instructions - Please Read Carefully!

- Please complete front side of the form only. Use a No. 2 pencil. Do not use ink pens.
- Make solid marks that fill the response completely and make no stray marks.
- Print neatly in BLOCK LETTERS.

CORRECT: ● INCORRECT: ✓ ✗ ◒

CORRECT: A B C 1 2 3

**Last Name**

**First Name**

**Today's Date**

| MONTH | DAY | YEAR |
|---|---|---|
| Jan | | 2 0 0 |
| Feb | | |
| Mar | 0 0 | 2 0 0 8 |
| Apr | 1 1 | 9 |
| May | 2 2 | |
| June | 3 3 | |
| July | 4 | |
| Aug | 5 | |
| Sept | 6 | |
| Oct | 7 | |
| Nov | 8 | |
| Dec | 9 | |

**Date of Birth**

| MONTH | DAY | YEAR |
|---|---|---|
| Jan | | 1 9 |
| Feb | | |
| Mar | 0 0 | 1 9 0 0 |
| Apr | 1 1 | 1 1 |
| May | 2 2 | 2 2 |
| June | 3 3 | 3 3 |
| July | 4 | 4 4 |
| Aug | 5 | 5 5 |
| Sept | 6 | 6 6 |
| Oct | 7 | 7 7 |
| Nov | 8 | 8 8 |
| Dec | 9 | 9 9 |

**Age**

**Street Address**

**City** **ST** **ZIP Code** **Phone**

**Email**

Gender: ◯ Male ◯ Female

I hereby consent to the administration of wellness screening tests and agree to the terms and conditions listed on reverse: ◯ Yes ◯ No
I have fasted - no food and only water or black coffee - for at least 9 hours (not required to complete the screening tests): ◯ Yes ◯ No
I agree to share my results with my health plan, if applicable: ◯ Yes ◯ No
Do you smoke or use smokeless tobacco products? ◯ Yes ◯ No
Do you have a pacemaker or other implanted electrical device? ◯ Yes ◯ No
(Females only) Are you pregnant? ◯ Yes ◯ No

**Participant Signature**

## For Examiner Use Only

### Healthy Heart Screening Tests

| Total Cholesterol | HDL | TC/HDL Ratio | Tri-glycerides | LDL | Glucose | Height FT | Height IN | Weight (Pounds) | BMI | Systolic BP | Diastolic BP |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | . | | | | | | | | | |
| 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 3 4 5 6 7 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |
| NA N/A | NA N/A | NA N/A | NA N/A | NA N/A | NA N/A | NA N/A | | NA N/A | NA N/A | NA N/A | NA N/A |

### Other Screening Tests

**Diabetes**

| A1C% |
|---|
| 0 1 2 3 4 5 6 7 8 9 |
| NA N/A |

**Body Composition**

| Body Fat% | Waist (IN) | Hip (IN) |
|---|---|---|
| 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |
| NA N/A | NA N/A | NA N/A |

**Bone Density**

| T-Score |
|---|
| + 0 . 0 |
| − 1 2 3 4 5 6 7 8 9 |
| NA N/A |

**Heart**

| Heart Rate |
|---|
| 0 1 2 3 4 5 6 7 8 9 |
| NA N/A |

**Lung Function**

| FEV1 (%) |
|---|
| 0 1 2 3 4 5 6 7 8 9 |
| NA N/A |

Did participant receive DermaView screening?

◯ YES
◯ NO

**Site ID**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |

Examiner Initials: ____ Time of Screening: ____ : ____ ◯ AM ◯ PM

Consent for Administration of Wellness Screening Tests

I understand that this screening service is offered for my benefit and information. Screening tests are not meant to replace the care of my personal physician. I acknowledge that I may receive results that are considered “abnormal” as well as an explanation for these results. However, I also understand that screening tests can give false positive or negative results for a variety of reasons. I acknowledge that my physician is best able to interpret the results of these tests based on his/her understanding of my medical history. I also acknowledge that I have received a copy of the Summit Health, Inc. Notice of Privacy Practices. I understand that this document provides an explanation of the ways that my individual health information may be used or disclosed by Summit Health, Inc., and of my rights with respect to my health information. I have been provided the opportunity to discuss concerns I may have regarding the privacy of my health information.

I release and discharge Summit Health, Inc. and its shareholders, parent, subsidiaries, officers, directors, employees, franchisees and licensees, together with their respective affiliates, and the program sponsors and their agents, including the owners/operators of this facility and its parent, subsidiaries, officers, directors and employees (collectively, the “Released Parties”), from any and all claims or causes of action, on account of injury to me which may result from my participation in this screening (including a failure of the screening to detect any particular health problem), except for such claims or causes of action on account of injury to me resulting from the sole negligent acts or omissions, or willful misconduct, of the Released Parties. This release shall be binding upon my heirs, assigns, executors, administrators and representatives.

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