

Memorial Hospital and Manor Wellness Screening Information Form

Health Fair Name:	COMMUNITY HEALTH FAIR			Health Fair Date:	11/06/2026
Name:	Last	First	Middle	Date of Birth:	
Social Security #:			Race:		Sex:
Mailing Address:					
City, State, Zip:					
Daytime Phone:			Evening Phone:		
To receive and view your results online via your home computer or cell phone, please provide your email address:					
Primary Care Physician:			Physician Location City, State		
Testing: (Check all that apply)	☐ Cholesterol; Glucose		☐ PSA Screening (men age 50+only)		
I verify that I am: (Choose One)	☐ FASTING No food or drink for at least 8 hours		☐ NON-FASTING Had food or drink during the last 8 hours		
I hereby consent to having my blood drawn for screening purposes for this health fair. In consideration of having this test, I hereby release Memorial Hospital and Manor and any other organization(s) associated with this screening, their affiliates, directors, officers, employees, successors, and assigns from any and all liability arising from or in association with this screening or from data derived therefrom. I understand that: - The data derived from this health fair or service is for screening purposes only, and does not constitute a diagnosis or treatment of any kind. - If the results of the screening indicate a follow-up examination is necessary, the responsibility for obtaining a follow-up examination to conform or review these results is mine alone, and not the responsibility of any organization(s) associated with this screening. - I understand that this service is given to me as a health fair tool and as a benefit to me, and it is my responsibility to follow-up or arrange care with a Physician or Provider and to discuss the results or any testing performed during this health fair.					
Signature:			Date:		
LABORATORY USE ONLY					
Collection Time:			Collected By, Initials and Date:		
Wellness Profile = WELLP			Accession No		