Clark County Public Health Department

997 N York St, Martinsville, IL 62442

Phone: (217) 382-4207 ~ FAX: (217) 382-4226

http://www.clarkhd.org

ADULT HEALTH CONSENT

Address: _____, City: _____, State: ___

Phone/Cell Number: _____, Doctor: _____

Email Address: _____

I, _____ (DOB:_____) give

my permission to the Clark County Health Department to complete the following:

1. **NECESSARY EXAMINATIONS:**
   - Physical Assessments
   - Height
   - Weight
   - Other Measurements as needed

2. **LAB TESTING:**
   - Hemoglobin
   - Other (ex: Diabetes Screening)_____
3. Contact physician in regards to health records and any abnormal findings at WIC appointments.

4. Screen for prenatal and postpartum depression and send a letter to my physician if needed.

5. Refer and consult with the Crisis Pregnancy Center if needed.

6. What Insurance Carrier do you have: _____ _____
   Primary Secondary

(Circle one) **Not Hispanic or Latino/ OR/Hispanic of Latino**

(Circle one) **Asian, American Indian/Alaska Native, Black or African American, Native Hawaiian/ Other/ Pacific Islander, White**

Signature_____

Witnessed by _____

Date _____