Clark County
Health Department

P. O. Box 266
Martinsville, IL 62442
217-382-4207 Phone
217-382-4226 Fax

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

Signature_____

Witnessed by _____

Date _____

This institution is an equal opportunity provider.

Revised 7/22/2014 mm