CAREClinic

COLLABORATIVE • ACADEMIC • RESTORATIVE • ENGAGED

— HERZING UNIVERSITY —

Clearance Form

First Name: ____________________________ Last Name: ______________________________

□ Male □ Female DOB: ___________________

Home Address: _______________________________________ City: ___________________

State: ____________________ Zip: _________________

Phone (personal): _____________________ Phone (work): ________________________

E-mail Address: ____

How do you prefer to be contacted? □ Phone Call (personal) □ Phone Call (work)
□ Text Message □ E-mail

Emergency Contact: ___________________________ Relationship: ___________________

Phone: ________________________ Other Contact Means: ________________________

What are your concerns or reasons for coming to the Community Care Clinic?
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____
____

Do you have a primary care provider? □ Yes □ No. Date of last visit: ______________

If yes, please include the provider's practice name or group: _____________________________

Provider's Phone Number: _____________________________________

Provider's Address: ____

Do you have a physical therapy provider? □ Yes □ No

If yes, please include the therapist's name or group: ____________________________

Provider's Phone Number: ____________________________________

Provider's Address: ____

How did you learn about the Community Care Clinic?

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Health History

How would you rate your overall health? □ Excellent □ Very Good □ Good □ Fair □ Poor

Have you been hospitalized in the past 6 – 12 months? □ Yes □ No. If yes, please explain:

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____

Are you currently employed or going to school? □ Yes □ No
If yes, where and to what capacity?

____

____

____

Are you allergic to anything? □ Yes □ No. If yes, please explain:

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____

____

Have you had any surgeries? □ Yes □ No. If yes, please explain including surgery date(s):

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____

Do you take any prescribed medications? □ Yes □ No. If yes, please list or attach a list:

____

____

____

Do you take any over the counter medications, vitamins, or supplements? □ Yes □ No
If yes, please list or attach a list:

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____

Past Medical History (check all the apply):

□ Alzheimer's	□ Diabetes	□ Infusion Pump (indwelling)	□ Pacemaker
□ Anemia	□ Emphysema	□ Irregular Heartbeat	□ Parkinson's Disease
□ Anxiety	□ Fibromyalgia	□ Kidney Dialysis	□ Seizures
□ Arthritis	□ Gallbladder Disease	□ Kidney Infection	□ Spinal Cord Injury
□ Artificial Joint	□ Headaches	□ Kidney Stones	□ Stomach Ulcer
□ Asthma	□ Heart Attack	□ Mental Illness	□ Stroke/TIA
□ Blood Clots	□ Heartburn/GERD	□ Metal Implants	□ Thyroid Disease
□ Bruising	□ Hepatitis	□ Mitral Valve Prolapse	□ Tuberculosis
□ Cirrhosis	□ Hiatal Hernia	□ MRSA	□ Vitamin Deficiency
□ Congestive Heart Failure	□ HIV/AIDS	□ Osteopenia	□ Cancer
□ Depression	□ Hypertension	□ Osteoporosis	Type: ____________ __________________

Other: ____

Participant's Printed Name: ____ Age: ___________

Participant's/Guardian's Signature: __________________________________ Date: ___________

CARE Clinic Staff Only:

PT Reviewed:___________________________________ Date:___________________

Participant Informed Consent

Herzing University places the safety and well-being of the participants first. Therefore prior to the participant's initial visit with Herzing University faculty and students, they must be informed of and consent to the below terms, agreements, and conditions.

Terms:
The Herzing University Community Care Clinic is a teaching and learning experience created to introduce students to community members. Students are not licensed physical therapist assistants but they are supervised by faculty whom are qualified and licensed physical therapists.

1. The wellness services provided by students and faculty are not designed to replace any type of medical care including rehabilitation.
2. Students work under the supervision of the faculty aforementioned. The faculty's role is to assure safety of all parties involved and they may intervene during any part of the visit for safety and/or teaching purposes.

Agreements:
Participants do not have current medical conditions limiting their participation in the wellness clinic.

1. Participants are responsible for seeking medical care independently and will communicate pertinent information to students and/or faculty. Wellness clinic services may be deferred based on circumstances to ensure participant safety.
2. Any personal information provided by the participant is kept confidential unless the release of information is necessary for their safety and/or wellbeing; the information may only be shared with the participant's provided primary care provider and/or physical therapy provider.

Conditions:
I, the participant, assume all of the risks of participating in all activities associated with the Herzing University Community Care Clinic. Including by way of example and not limitation, any risks that may arise from negligence, from dangerous or defective equipment or property owned, maintained, or controlled by them, or because of their possible liability without fault. I certify that I have not been advised to not participate by a qualified medical professional. I certify that there are no health-related reasons or problems which preclude my participation in this activity.
INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in this document from any and all liabilities or claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise.
I understand while participating in this activity, I may be photographed. I agree to allow my photo, video, or film likeness to be used for any legitimate purpose by Herzing University.
I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

______________________________ __________ ________________________________ ______
Participant's Signature Date Participant's Name (Please print legibly) Age

______________________________ __________
Parent/Guardian's Signature Date
(If under 18 years old, Parent or Guardian must also sign and Parent or Guardian shall remain on premises during participation)