



Health Fair Screening Consent Form

Patient Information

- Full Name: _____
- Date of Birth: _____
- Phone Number: _____
- Email Address: _____

Screening Consent

I, _____, hereby consent to participate in the health fair screening organized by DHHS MOBILE HEALTH CLINIC. I understand that this screening aims to provide me with important health information and recommendations based on the results.

I acknowledge the following:

1. **Purpose:** The purpose of the health fair screening is to identify potential health risks and provide education and resources to promote well-being.
2. **Confidentiality:** The information collected during the screening will be kept confidential and will only be shared with necessary healthcare professionals and staff involved in the event.
3. **Voluntary Participation:** My participation in the health fair screening is voluntary, and I understand that I have the right to refuse or discontinue any specific test or procedure at any time.
4. **Informed Decisions:** I have received adequate information about the screening procedures, tests, and potential risks or benefits. I have had the opportunity to ask questions, and my concerns have been addressed satisfactorily.
5. **Results and Recommendations:** I understand that the screening may provide me with results and recommendations based on the data collected. These results are intended for informational purposes only and should not replace a comprehensive medical evaluation by a qualified healthcare provider.
6. **Follow-up Care:** If further evaluation or treatment is recommended based on the screening results, it is my responsibility to seek appropriate healthcare services.
7. **Limitations:** I understand that the health fair screening has its limitations and may not detect all possible health conditions or risks.

8. **Media Release:** I hereby grant permission to DHHS MOBILE HEALTH CLINIC to use any photographs or videos taken during the health fair screening for promotional, educational, or fundraising purposes.

Commented [DLZC1]: Shall this be included in the consent form?

Please provide with your initials here if you agree to media release: _____
If you do not agree please leave blank. Thank you.

By signing this consent form, I acknowledge that I have read and understood all the information provided and agree to participate in the health fair screening voluntarily.

Signature

Patient Signature: _____
Date: _____

Parent/Guardian Signature (if applicable): _____
Date: _____