



Blood Pressure Screenings
 Blood Glucose Screenings
 Prostate Health Information
 Participating Locations Statewide
 www.in.gov/icssbm
 info@icssbm.in.gov

Participant Screening Registration Form

This section will be completed by a medical volunteer.

Blood Pressure

Glucose

Barbershop: _____

Date: _____ Time: _____

Sex: Male Female

Date of Birth: _____ County: _____

Name: _____

Address: _____

Phone: _____

City: _____ Zip Code: _____

Email: (optional) _____

Age: _____ Height: _____ Weight: _____

READ AND SIGN

- I understand that it might be necessary to draw a small amount of blood to conduct some of the tests and/or research and the risk of doing so has been fully explained to me. I hereby consent to and authorize the medical volunteer to do screenings on myself. The purpose of which is to determine health status. I understand the test results are confidential, and will not be shared. No other entities will receive test results except, after removing identifying information, for statistical purposes.
- I understand that I may revoke the consent for screenings on myself at any time by notifying the Indiana Commission on the Social Status of Black Males in writing, but if I do, it won't have any effect on any actions taken before receipt of the written revocation.
- I have read this release of liability and assumption of risk agreement. I fully understand its terms, understand that I have given up substantial rights by signing and sign it freely and voluntarily without any inducement.
- I will undergo the procedures of having my blood measure and having my finger punctured by a sterile instrument designed specifically for this purpose. Though the risk of complications from these procedures is very low, I acknowledge the fact that a secondary infection could result from the puncturing of my skin which might require prompt medical attention. Knowing this risk, I agree to completely hold harmless all of the volunteers, organizers and sponsors of this event should this or any other negative outcome occur as a result in my participation in this event.

(Signature)

(Date)

(Time) am/pm

(Witness)

It is important that you understand that these procedures are not diagnostic in nature, and do not replace visits to your family doctor.

For participants of minority age (under age 18)

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree not only to his/her release of the Indiana Black Barbershop Health Initiative and all other releases from any liabilities incident to his/her involvement in this program for myself, my heirs, assigns, and next of kin.

Parent/Guardian Signature

Medical Screenings

Blood Tests

Blood Sugar

Cholesterol

PSA (Prostate Cancer Screening) (Men Only)

Other Tests

Blood Pressure

Right Arm ____/____

Left Arm ____/____

Resource Guide

Yes No



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Photo Release Statement

I grant the Indiana Commission for the Social Status of Black Males (ICSSBM) the right to take photographs of me in connection with the above-identified event. I authorize the ICSSBM, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that the ICSSBM may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature _____

Printed name _____

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Signature, parent or guardian _____
 (if under age 18)

Please Tell Me

Please tell me which of the following best describes your ethnic origin or race?

African/Black Caucasian/White Hispanic/Latino Asian/Pacific Islander Native American Other

What is the highest level of education you have completed?

No H.S. H.S./GED Some College College Graduate Some Graduate School Graduate Degree

We don't need to know exactly, but just roughly what is your annual household income before taxes?

Under \$15,000 \$15,000-\$24,000 \$25,000-\$34,999 \$35,000-\$49,000 \$50,000-\$74,000 \$75,000-\$99,999 \$100,000 or more

Would you say that, in general, your health is: Excellent Very Good Good Fair Poor

What is your marital status? Married Single Divorced/Separated Widowed Living w/significant other

Do you have health insurance? Yes No If "Yes", check all that apply:

Medicaid _____ Medicare _____ Private Insurance _____ Other _____

Do you have a primary care doctor?

If yes, then please provide your doctor's contact information:

Name: _____

Address: _____

Telephone: _____

Email: _____

If no, then where do you mainly go to receive health care?

Alternative Medicine Provider Private Doctor's Office Hospital Emergency Room

A Free Clinic HMO Other

How many total servings of fruits and vegetables did you eat yesterday? (A serving would equal one medium apple, a handful of broccoli, or a cup of cut carrots)

1-3 servings 3-5 servings 5-7 servings 8 or more

How often do you smoke cigarettes? Every Day Some Days Not At All

Have you ever been told by a doctor that you have high blood pressure or hypertension? Yes No

Do you take any blood pressure or water pills that a doctor prescribed for you? Yes No

Do you take insulin or pills for diabetes? Yes No