

Family Pharmacy Clinical Services Health Test Consent Form

Blood Pr	essure	_	•			□Hemoglob	oin A1C		
Dationt Name					Da	to of Rirth:	. /	,	
Patient Name: _	First		 MI	Last	Da	te of biftin.	·/ MM/D!	/ D/YYYY	
Sex: □ M □ F						lress:			
							(Optional)		
Address:	Street or P.O. Box			City	State Zip				
Primary Physician:						State	Zip		
Primary Physic	ıan:								
The following quest	tions will help o	determine	your eligibili	ity.				YES	NO
1. Do you feel sick									
2. Do you have alle	raina to modia	ations for	d later on r	raginas? If	na places liet:				
2. Do you have alle	rgies to illeuic	ations, 100	u, iatex, or v	accines? II s	o, piease list:				
3. Have you eaten a	a meal in the la	st 8 hours	;?						
4. Do you have any	health conditi	ons/disea	ses? If so n	lasca lict:					
4. Do you have any	nearth contact	ons/uisea	.ses: 11 so, p	icase iist.					
Place Rx Label Here				7 [For Clinic Use Only Clinic Name: Family Pharmacy				
					Date of Test: Initials:				
					Result(s): Blood Pressure	à.			
					Blood Glucose): 	Hem A1	C	
					Blood Pressure Blood Glucose Cholesterol:	Total:	HDL: _		
					Cassette	LDL:	1 rig: Exp:		
							Exp		
I certify that I am a consent to the hea finger stick blood s given the opportunand employees fro above. I acknowled	lthcare provid sample if nece nity to ask any m any and all	ler of Fam ssary. I un questions liability a	ily Pharmac derstand the s that I may rising from o	y to admini e benefits an have. I here or in any wo	ster the test(s) nd risks of recei by release Fam ny related to the	I have requestiving the abovilly Pharmacy eadministration	ted above, ove test(s), and all officion of the test	and drav nd I have icers, dir est(s) lis	e been ectors,
Signatura						Data	,=		