SHRIJI MANDIR
& CULTURAL CENTER
15700 Woodruff Avenue
Bellflower, CA 90706

Phone: 562-461-3921
shrijimandirla@gmail.com
http://shrijimandirla.org
Tax ID # 06-1689071

HEALTH SCREENING FORM

Date: ____ /____ /____ Registration Number: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____ /____ /____ Age:_____ Sex: ☐ M ☐ F Occupation: _____
MM DD YYYY

Address: _____ City: _____ Zip: _____

Home Phone: (_____) _____ Email Address: _____

Emergency Contact: Name: _____ Phone Number: (_____) _____

Medical Insurance ☐ Yes ☐ No

Personal Physician: _____ Physician's Phone: (_____) _____

Do you smoke	☐	Diabetes	☐	Breathing Disorders	☐
Do you drink	☐	Abdominal pain	☐	Difficulty Urinating	☐
Had surgeries	☐	Nausea, vomiting	☐	Blood in urine	☐
Problem w/ eyes	☐	Blood in stool	☐	Gynecological problems	☐
Problem w/ ears	☐	Joint/Muscle Problem	☐	PAP smear Year:	☐
Heart Disorder	☐	Nervous Disorder	☐	Mammogram Year:	☐
High Blood Pressure	☐	Allergies	☐	Other	☐

CONSENT TO HEALTH SCREENING AND WAIVER OF LIABILITY

I understand, acknowledge, and agree to the following:

1. I am voluntarily participating in this health screening.
2. This health screening is being conducted by volunteer doctors, dentists, and pharmacists, and other health care professionals/assistants ("volunteers") for mine and other participants benefit, and is preliminary in nature.
3. Shriji Mandir, its directors, officers,member, and other participating health care volunteers make no claim, representation or guarantee with respect to the accuracy or precision of their evaluations due to the limited resources available at this screening .
4. It is my responsibility to follow up on any recommendations that are made to me during this screening and obtain follow up advice, testing, and diagnosis from my personal physician.
5. I also understand that for acute/emergent medical care I need to contact my personal physician or go to the nearest hospital emergency room or call 911.
6. I agree to indemnify and hold harmless the Shriji Mandir its directors and officers, employees, representatives, and volunteers from and against all claims, demands, defense costs, liability, consequential damages of any kind or nature arising out of or in connection with this Free Clinic/Health Fair, and expenses (including attorney's fees and court costs) arising out of advice given or not given, test conducted or any act of inaction on the part of this participating Organizations of the volunteers of any of them, during or after this Health Screening. I fully understand that my participating in this Free Clinic/Health Fair is voluntarily and is of my own free will; the health screening process will be rendered by volunteers only, no compensation is expected or will be charged. By rendering my consent to this screening process, I understand that I am not receiving medical services and therefore agree to indemnify and hold harmless the participating Organizations, City and City Officials, Volunteers, and City authorities from any and all claims, liabilities, including attorney fees and Court costs, arising from my participation or the advice given or not given, test(s) conducted or as a result of this health screening. The undersigned also grants Shriji Mandir (The Gujarati Society) to photograph recordings and take videos of this event(s) and utilize and display for general use and publicity purpose without further permission.

Signature: _____ **Witness:** _____

Doctor: _____

Patient's Name (Last,First) _____

Pulse: _____ Blood Pressure: _____ Weight: _____

Lab: ☐ CBC ☐ Cr ☐ Glucose ☐ Lipid Panel ☐ PSA ☐ Other: _____

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HEALTH SCREENING
PROGRESS NOTE:

Doctor: _____

Pulse: _____ Blood Pressure: _____ Weight: _____ Height: _____

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PROGRESS NOTE:

Doctor: _____

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