

Executive Health Health Risk Assessment Informed Consent

DESCRIPTION

The purpose of the Health Risk Assessment screening is to provide information regarding your present level of health and fitness. The following screening tests will be administered unless contraindicated or participation is declined. The tests will include:

- Height, weight, frame size
- Blood pressure
- Body composition
- VO₂ max fitness test

BENEFITS

The screening results will provide information regarding your present level of health and fitness. Suggestion on general lifestyle behaviors will also be addressed. The data derived from the screening tests is *preliminary* and **does not** constitute a medical diagnosis. It is the participant's sole responsibility to follow-up with his or her physician to obtain professional medical assistance and confirm any results.

RISKS AND DISCOMFORTS

Due to the nature of the various tests certain risks do exist. These risks may include, but are not limited to: abnormal blood pressure, abnormal pulse rate, dizziness, fainting, muscle soreness and in very rare instances heart attack and stroke. Every effort will be made to minimize these risks through the preliminary medical history, proper test protocol and close observation during testing. Emergency personnel will be called if the situation should arise.

FREEDOM OF CONSENT

Questions about the procedures used in the health and fitness testing are encouraged. **YOU ARE IN CHARGE — if at any time during the test you wish to stop, notify the testing staff promptly.**

Signs to report to the testing staff immediately:

- Tightness, squeezing or pain in the chest
- Light headedness
- Unusual feelings or sensations
- Nausea
- Joint pain
- Any type of discomfort or pain

Permission to perform this health and fitness evaluation is **voluntary** and participation in any test is **optional**. Information obtained is strictly **confidential**; however, it may be used for statistical or scientific purposes with your right of privacy retained.

I hereby release Park Nicollet Institute and any other organization(s) associated with this screening, their affiliates, directors, officers, employees, successors and assigns, from any and all liability arising from or in any way connected with this screening.

Having read this form, I hereby consent to engage voluntarily in the Health Risk Assessment testing. I understand the procedures to be used as well as possible complications that could occur. I am not aware of any reason why I should refrain from participating in this health risk assessment. I further acknowledge that all the questions asked have been answered to my satisfaction. I agree to report any abnormal symptoms immediately to the tester and I understand that I may terminate any test at any time. I understand the data from these tests is only preliminary and does not constitute a medical diagnosis. The responsibility to initiate a physician follow-up to confirm any of the results of this screening are mine alone and not that of the organization providing the screening.

Signature: _____

Date: _____

Medical Clearance for Health Risk Assessment

You need a physicians consent ONLY if you have one or more of the following conditions:

1. Resting blood pressure greater than 140/90mm/Hg.
2. Currently taking medication for a heart condition or acute medical condition.
3. Currently pregnant.
4. Cardiovascular abnormalities (chest pain, shortness of breath, stroke, bypass surgery, heart attack, blood clot, etc.).
5. Chronic back condition, arthritis or other bone/joint problems.
6. Emphysema, acute asthma or other breathing difficulty.
7. Epilepsy or other neurological difficulty.
8. Glaucoma.
9. Chronic infections disease (mono, hepatitis, HIV).

I have examined _____ and approve of his/her participation in an exercise program and/or fitness test which may include, sub maximal/maximal VO₂ tests, and muscular strength and flexibility assessments.

Please elaborate if there are any tests or exercises that should not be performed, or if there are special conditions the testing staff should be aware of:

Comments or concerns: _____

Physician's Name: _____
(PLEASE PRINT)

Date: _____

Physician's Signature: _____

Clinic: _____

Phone: _____