SCREENING AUTHORIZATION/RELEASE FORM

HEMOGLOBINOPATHY SCREENING

Date _____

Instructions: Please complete this form with black ink in the spaces provided. You will receive your results in the mail.

Please Print

Name: _____ School/ Agency_____

Age:_____ Date of Birth: _____ Race: _____ Sex: _____

Address: _____ Telephone No: (_____)_____

City: _____ State: _____ Zip Code:_____

I hereby, **release** North Central Indiana Comprehensive Sickle Cell Initiative and any other organization involved in this program, and their agents, from all liabilities, medical claims or expenses which may arise from my participation or any injury sustained during this event. I recognize and accept all risk associated with this screening. I understand that the program will only screen for hemoglobin variants and does not constitute medical examination or diagnosis. For a diagnosis of a medical problem, I must see a physician for a complete examination.

I, the undersigned, hereby authorize the North Central Indiana Comprehensive Sickle Cell Initiative to perform a finger stick.

Date: _____ Parent Signature: _____

If you are under 18 years of age, this form must be signed by parent or guardian.

LABORATORY TEST(S)

_____ _____
Iso-Electric Focus **Phenotype**

_____
_____
Technician **Intake Person** **Date Processed**

Letter sent _____ Appointment made for follow up _____
Date and Initials **Date and Initials**

Supported by: Memorial Health Systems
South Bend Medical Foundations