Attachment C: Capital Area Human Service District
Consent to Medical Procedures Performed at CAHSD Facilities*

Date: _____Client: _____D.O.B._____

I, the undersigned, a client of _____ (CAHSD Clinic/Program), hereby authorize the physicians of said organization (and whomever they may designate as their assistants) to perform the following medical screening procedures as indicated:

- ☑ PHYSICAL EXAMINATION (residential substance abuse/addiction services only)
- ☑ TUBERCULIN SKIN TEST / TUBERCULOSIS SYMPTOM SCREENING (residential and outpatient substance abuse/addiction services)
- ☑ VENIPUNCTURE FOR BLOOD SPECIMEN COLLECTION
- ☑ VITAL SIGNS CHECK (TEMPERATURE, PULSE, RESPIRATION, BLOOD PRESSURE, WEIGHT, HEIGHT, BODY MASS INDEX)
- ☑ FINGERSTICK BLOOD GLUCOSE / TOTAL CHOLESTEROL
- ☑ URINE / SALIVA / BREATHALYZER ALCOHOL/DRUG SCREENS
- ☑ URINE PREGNANCY TEST
- ☑ OTHER: _____

In addition, I agree to participate and cooperate with the collection of personal medical information needed for the medical screening procedures.

I hereby certify that I have read the Consent to Medical Screening form and understand the authorization. I understand that medical procedures entail some risks, which have been explained to me. I certify that no guarantee or assurance has been made as to the results that may be obtained from any treatment or procedure.

Client/Guardian Signature: _____ Date: _____

Client Representative Signature: _____ Date: _____
(If applicable)

Witness Signature: _____ Date: _____

*Not applicable to School-Based Behavioral Health.