



ADULT HEALTH CONSENT

I, _____ (DOB: _____) give

my permission to the Clark County Health Department to complete the following:

1. NECESSARY EXAMINATIONS:

- Physical Assessments
- Height
- Weight
- Other Measurements as needed

2. LAB TESTING:

- Hemoglobin
- Other (ex: Diabetes Screening) _____

3. Contact my physician and/or the Regional Behavioral Health Network (RBHN) in regards to health records and any abnormal findings at WIC appointments.
4. Screen for prenatal and postpartum depression and refer to my physician/RBHN, if needed.

Signature _____

Witnessed by _____

Date _____

This institution is an equal opportunity provider.