

# KAUAI'S GREAT 2007 WEIGH OUT

## Participant Registration Form

**I would like to register for: (Please check or circle one only.)**

<input type="checkbox"/> <b>Team Member</b> <b>Fee: \$10</b>	Our Team Name is: _____												
<input type="checkbox"/> <b>Me Too!</b> <b>Fee: \$10</b>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: left;"><i>Best Way to Contact Me:</i></td> <td style="text-align: center;"><i>Phone</i></td> <td style="text-align: center;"><i>USPS Mail</i></td> <td style="text-align: center;"><i>E-Mail</i></td> </tr> <tr> <td colspan="4">I was recruited by: _____ of _____ team.</td> </tr> <tr> <td colspan="4">My t-shirt size: XS    S    M    L    XL    XXL    XXXL    XXXXL    XXXXXL</td> </tr> </table>	<i>Best Way to Contact Me:</i>	<i>Phone</i>	<i>USPS Mail</i>	<i>E-Mail</i>	I was recruited by: _____ of _____ team.				My t-shirt size: XS    S    M    L    XL    XXL    XXXL    XXXXL    XXXXXL			
<i>Best Way to Contact Me:</i>	<i>Phone</i>	<i>USPS Mail</i>	<i>E-Mail</i>										
I was recruited by: _____ of _____ team.													
My t-shirt size: XS    S    M    L    XL    XXL    XXXL    XXXXL    XXXXXL													

**This form must be completed and submitted with your registration fee. Submit in person or by mail to Ho'ōla Lāhui Hawai'i at 4491 Rice St., Unit 6 Lihu'e, HI 96766.** (Make checks payable to Ho'ōla Lāhui Hawai'i).

**Name:** \_\_\_\_\_  
Last                      First                      Middle Initial

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Residence address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Other # \_\_\_\_\_

E Mail Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_    Gender: [ F ] [ M ]

Do you have medical insurance? Yes No    If yes, name of insurance company: \_\_\_\_\_

Do you have a primary care provider: Yes No    If yes, name of doctor: \_\_\_\_\_

**(1) Ethnicity: (Select one only)**

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> More than 50% Hawaiian        | <input type="checkbox"/> Chinese     | <input type="checkbox"/> Pacific Islander     |
| <input type="checkbox"/> Less than 50% Hawaiian        | <input type="checkbox"/> Filipino    | <input type="checkbox"/> Hispanic (all races) |
| <input type="checkbox"/> White (Non-Hispanic)          | <input type="checkbox"/> Japanese    | <input type="checkbox"/> Black                |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Other _____          |

**(2) Primary Language:**

- English
- Hawaiian
- Other: \_\_\_\_\_

**(3) Martial Status:**

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Divorced            | <input type="checkbox"/> Married   |
| <input type="checkbox"/> Single w/o partner  | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Single with partner | <input type="checkbox"/> Widow     |

**(4) Homeless:**

- |   |   |
|---|---|
| <input type="checkbox"/> Not homeless     | <input type="checkbox"/> On the street    |
| <input type="checkbox"/> Homeless Shelter | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Doubling Up      | <input type="checkbox"/> Yes, but unknown |

**(5) If Homeless – Dates**

From: \_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_  
MM YY                      MM YY

- (6) Family Income (Yearly):**  \$0-10,700     \$10,701-14,360     \$14,360-18,019     \$18,020-21,679
- \$21,680-25,339     \$25,340-29,099     \$29,100-32,659     \$32,660-36,319     \$36,320-39,979
- \$39,980-43,639     >\$43,640

Family Size: \_\_\_\_\_

**Client Policy and Procedures:** *(Please initial)*

\_\_\_\_\_ I have received a copy of the "HIPAA Notice of Privacy Practices".

\_\_\_\_\_ I have received a copy of the "Client's Rights and Responsibilities and Grievance Procedure".

\_\_\_\_\_ I understand that there will be a \$20.00 service charge for all returned checks.

**EMERGENCY CONTACT INFORMATION**

**List person we may contact in case of emergency (If possible someone from outside the home.)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Waiver and Consent Agreement:**

I consent to participate voluntarily in the Kaua`i Great Weigh Out. I am aware that this program includes health screenings which include but is not limited to monitoring of blood pressure, weight, body mass index, and a lipid profile. I understand that any information obtained will be kept confidential and used only for statistical data and my own benefit. My signature next to my name acknowledges that I agree for myself, my heirs, executors and administrators to release, indemnify and hold harmless all Kaua`i Great Weigh Out core committee members and Ho`ōla Lāhui Hawai`i committee members, its affiliates, officers, directors, employees, volunteers and all sponsoring businesses and organizations and their agents and employees from any and all liability, claims, demands and causes of action whatsoever arising out of my participation in this event and related activities, whether it results from negligence of any of the above or from any other cause. I further agree that this consent and waiver agreement shall be applicable to any owner of a facility and/or property at or upon which the program is held. I am solely responsible for my own health and safety. I represent that I am physically fit and able to participate in this program. I am hereby, advised to consult my physician before participating in this program. Furthermore, I hereby grant full permission to any and all of the foregoing to use my name, my voice and or my picture or likeness in any broadcast, telecast, advertising, promotion or other account of this event for any purposes whatsoever. I have read, understand and agree to the terms of this agreement and have, of my own free will, signed below to indicate so.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If other signing, print name: \_\_\_\_\_

Witness: \_\_\_\_\_

\*\*\*\*\*  
\*\*\*\*\*

Form: KGWO Patient Registration

Effective Date: 1/02/07

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Revised Date: 12/06

\_\_\_\_\_  
Healthy Hawaiian Lifestyle ( ) New ( ) Update