

Carroll College Mobile Health Unit
Informed Consent and Indemnification Agreement



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Patient Name: _____

Date of Birth: _____ **Date of Service:** _____

Carroll College, through its Nursing Program, operates a Mobile Health Unit that offers basic health assessments conducted by nursing students under the supervision of a licensed nursing faculty. Services provided may include:

- Basic health screenings and general wellness assessments
- Health promotion and illness prevention measures
- Supportive services to enhance overall health and well-being
- Health education and information on community health resources

These services are non-diagnostic and are not a substitute for a comprehensive medical evaluation or treatment by a licensed healthcare provider.

Acknowledgement of Limited Services

By signing this form, I acknowledge and agree to the following:

1. The services provided are for screening and educational purposes only.
 2. Services are provided by nursing students under the supervision of licensed nursing faculty.
 3. No formal diagnosis or medical treatment will be made based on these assessments.
 4. If my condition or assessment suggests the need for further attention, I will be advised to seek immediate medical care or, if necessary, referred to Emergency Medical Services (EMS).
 5. I am responsible for following up with a licensed healthcare provider regarding any findings or concerns that arise during this visit.
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Assumption of Risk and Indemnification

I further acknowledge and agree that:

1. The services provided are limited in scope, and there is an inherent risk of misinterpretation or incomplete assessment due to the educational nature of the Mobile Health Unit.
2. Carroll College, its faculty, students, and employees shall not be held liable for any adverse outcomes resulting from:
 - Use or misuse of the health screening information
 - Misinterpretation of results
 - Failure to obtain appropriate follow-up care
3. I **voluntarily assume all risks** associated with receiving services from the Mobile Health Unit.
4. I hereby **release, waive, and hold harmless** Carroll College, its employees, students, agents, and affiliates from any and all claims, liabilities, damages, or expenses that may arise from or related to services rendered at the Mobile Health Unit.

Consent to Participate

I confirm that I have read and understood the information provided above. I have had the opportunity to ask questions and voluntarily consent to participate in the services offered by the Carroll College Mobile Health Unit. I understand that these services are not a replacement for care provided by a licensed healthcare professional.

Signature of Patient (or Parent/Guardian if under 18): _____

Print Name: _____

Date: _____