

STARS PROGRAM

Registration Sheet

DATA REQUIRED BY PRIVACY ACT OF 1974

1. AUTHORITY: 5US Code 301; 10 US Code 1071; 42 US Code, 44 US Code 3101.
2. PRINCIPLE PURPOSE(S): Provide means for medical and allied medical personnel to link pregnancy PT information to patient's health care files/information.
3. ROUTINE USES: The primary use of this information is to provide, plan, and coordinate health care and a safe physical training environment for pregnant soldiers. Additionally, this information is used to compile statistical data, conduct research, evaluate care rendered, and evaluate program.
4. MANDATORY OR VOLUNTARY DISCLOSURE: Voluntary, however, failure to provide information may prevent continuity of care and prevent coordination with the patient's health care providers.

Name: _____ **Today's Date:** _____
LAST, FIRST, MI DD/MM/YY

Rank: _____ **Unit:** _____
Unit and unit's mailing address

Unit Phone: _____ **Birth Date:** _____
DD/MM/YY

Home Address: _____
FORT POLK AREA - FULL MAILING ADDRESS

Home Phone: _____ **SSN:** _____/_____/_____

Date Arrived at Ft. Polk: _____ **EDC:** _____
DD/MM/YY Date baby is due DD/MM/YY

Number of times pregnant: _____ **Number of live births:** _____
Include this pregnancy Before this pregnancy

MOS: _____ **Height:** _____ **Pre-pregnancy weight:** _____ **PT score:** _____
INCHES POUNDS LAST PT TEST

Permanent Home Mailing Address:

Married: _____ **Spouse's Name:** _____
Y or N

Profile: _____

Health/Past Pregnancy Problems:

FOR OFFICE USE ONLY:

Data Input: _____ Start Date: _____ Referral (Clinic) Source: _____ Physician _____

MEMORANDUM OF AGREEMENT



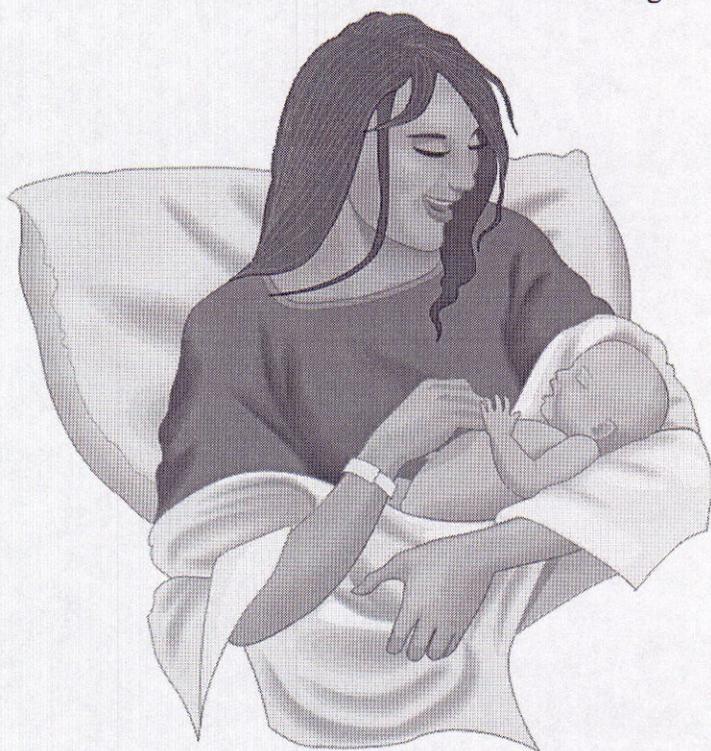
DATE _____

I have received information on the STARS Program. I understand that I am expected to conduct myself in a military manner at ALL times and that failure to do so or failure to be at the designated time in the designated uniform will result in counseling and unit notification.

I understand that I am expected to participate in the STARS program and that any questions or concerns will be directed to the Instructor or OIC's.

Print Name

Signature



Health Assessment Questionnaire

This is a medical history form to be completed prior to your participation in an exercise program. The information provided will be kept strictly confidential and will be used to evaluate your health and readiness to begin an exercise program.

Personal Information

Name _____

Sponsor's Name and last four of Social Sec. Number _____

Address _____

Contact Phone Numbers _____

Primary Health Care Provider _____

Health History

Do you smoke? If so, how much?

Has your doctor ever said you have high or low blood pressure?

Do you have any known cardiovascular problems (i.e. previous heart attack, arteriosclerosis, etc.)?

Do you have any injuries or orthopedic problems?

Are you pregnant or post-partum less than six weeks?

Are you diabetic?

Are you taking any prescribed medications or dietary supplements?

Comments or additional information:

Consent Form

I acknowledge, to the best of my ability, that I am in good health and have no known medical problems that would restrict my ability to participate in an exercise program.

Signed _____ Date _____