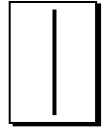




Guest Registration

Registration Number: _____



Welcome to this Clinic sponsored by Touched Twice United, a non-profit corporation. We offer health services from licensed professionals, food, clothing, and other items – all for free. Why? Because we love you, and we pray that you will get a spiritual blessing here as well. A person call an “Advocate” will help you through the Clinic today. Volunteers with colored nametags can also help you.

Each guest who receives services needs to fill out a form, including the children of parents who are guests. All information will be kept confidential.

Full Name: _____ Age: _____

Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

Religious Preference: _____

House of Worship: _____

May we have someone from a local church contact you? yes no

Please check the services you want today. Then CIRCLE the one that is most urgent to you. Below is a list of services. Due to last minute cancellations, services may be different today, and there may be more demand for some services than we can supply. We will try our best to meet your most urgent needs.

- Medical screening, Vision screening, Haircut, Massage, Manicure, Pedicure, Other: (repeated 8 times)

Please keep all Clinic forms with you until you check out at the Exit Desk. Do not take them home.

Advocate's name: _____



Touched Twice United

Meeting Human Needs in Christ's Name

www.touchedtwiceunited.org

P.O. Box 732 Chippewa Falls, WI 54729 (715)379-0858 contact@touchedtwiceunited.org

Volunteer Registration

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

Home Church: _____

Please contact me to serve at future events. yes no

I would be interested in connecting with a small group. yes no



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General Medical Form

Local Clinic Site: _____

I, the undersigned, understand that I am attending a free medical screening clinic. What this means is that the medical providers working with me will be listening to me concerning my basic, non-urgent needs, then directing me toward medical resources. They will not however, be providing comprehensive medical care.

I understand that this service is being provided free of charge and **agree not to hold the medical providers themselves personally liable** for any adverse health-related outcomes. I further **agree not to hold Touched Twice United or any of the churches and organizations serving me today liable** for any adverse health-related outcomes.

Name (printed): _____

Signature: _____ Date: _____

Age: _____ Sex: **M F** Date of Birth: _____ Occupation: _____

Chief Complaint: _____

When was your last medical appointment? _____ (Dr.): _____

Medications: _____

Allergies: _____

Tobacco: **Y N**

Alcohol: **Y N**

Marital Status: **C M S D W**

Clinician Use Only – please document significant clinical findings and treatment provided

BP _____ P _____ T _____ Wt _____ Ht _____ BMI _____ Glucose _____

Assessment:

Plan: