

**Membership Application**

# Healthy Nation Wings



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De-go-ya-dv

***Wings is a self-paced incentive based program developed to promote the importance and awareness of regular physical activity, health education, and nutrition for a healthier lifestyle.***

**3 Ways Wings Can Work For You:**

1. Earn prizes by completing and turning in weekly activity logs.
2. Sign up and attend the Wings sponsored Walk/Runs.  
Or you can.....
3. DO BOTH: complete activity logs and attend any of the Wings sponsored walk/runs.  
Prizes and Fun all in one!!!

## JOIN TODAY!

Completion of the required forms is a prerequisite to starting the Wings Physical Activity Program. When all required paperwork is received by the Healthy Nation Program Office, the participant is officially enrolled in the program

**REQUIRED FORMS:**

- Informed Consent
- Participant Agreement
- PAR- Q / Letter To Physician
- Photo Media Release
- Notice of Health Information Practices

**For more information contact the Cherokee Nation/Healthy Nation Program Office or one of the County Wings Contacts:**

<b>Cherokee County</b> Shannon Fields, Data Entry Tech. Cherokee Nation Complex, Tahlequah 918-456-0671 Ext. 2711	<b>Delaware County</b> Betty King, Public Health Educator Sam Hider Jay Community Clinic *918-253-4271 Ext. 248
<b>Cherokee County</b> Lu McCraw, Public Health Educator Cherokee Nation Complex, Tahlequah *918-456-0671 Ext. 2260	<b>Sequoyah County</b> Patty Green, HP/DP Educator Redbird Smith Health Center *918-775-6150
<b>Cherokee County</b> Bunner Gray, HP/DP Educator Cherokee Nation Complex, Tahlequah *918-456-0671 Ext. 2615	<b>Adair County</b> Karen Rabon, Public Health Educator Wilma P. Mankiller Health Center *918-696-8852
<b>Mayes County</b> Kasy Allen, HP/DP Educator A-MO Salina Community Clinic *918-434-8500	<b>Muskogee County</b> Shirley Goodlin Muskogee Health Center *918-687-0201
<b>Nowata County</b> Rhonda Abel Nowata Primary Care Center *918-273-0192	<b>Rogers County</b> Lisa Lyon, Dietitian Claremore IHS *918-342-6200

Cherokee Nation Healthy Nation Program  
 ATTN: WINGS  
 P.O. Box 948 Tahlequah, OK. 74465-0948  
 Phone 1-800-850-0298 or 918-456-0671 Fax: 918-458-6224

**REQUIRED FORM- must complete and return**

# Informed Consent

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Student:  Yes  No School: \_\_\_\_\_

Native American:  Yes  No Tribe(s): \_\_\_\_\_

Home Phone No. (918) \_\_\_\_\_ Work Phone No. (918) \_\_\_\_\_

E-mail: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(State) (Zip) (County)

**As a member of Wings please choose how you will participate: (*must check one*)**

Complete weekly logs only  
 Attend Wings sponsored run/walks only  
 Complete weekly logs and attend Wings sponsored run/walks

**Did a Healthcare Provider refer you to the Wings Program?  Yes  No**

***If you answered YES please indicate the health care facility your received Wings information from:***

<input type="checkbox"/> AMO Salina Community Clinic <input type="checkbox"/> Sam Hider Community Clinic, Jay <input type="checkbox"/> Muskogee Health Center	<input type="checkbox"/> Nowata Primary Care Clinic <input type="checkbox"/> RedBird Smith Health Center, Sallisaw <input type="checkbox"/> Wilma P. Mankiller Health Center, Stilwell	<input type="checkbox"/> Bartlesville Health Clinic <input type="checkbox"/> Vinita Health Clinic <input type="checkbox"/> GA-DU-GI Health Clinic <input type="checkbox"/> Other _____
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*I understand that my participation with Wings involves physical exercise that may be strenuous at times. This activity involves risks and injuries that may occur during my physical fitness activity.*

*I understand and agree that I should be in adequate physical condition or acquire a recommended physician clearance before engaging in this fitness and exercise program.*

*In the event of illness, injury or accident during my fitness participation as a member of Wings, I or my parent/guardian if I am a minor child, hereby release, hold harmless, discharge and agree not to sue the Cherokee Nation, partner school systems and organizations, their employees or representatives, and owners/lessors of premises from all liabilities or damages brought in litigation by other persons or parties on behalf of participants. This includes, but is not limited to liability of illness, injury or accident, lost, stolen or damaged property, or other risks that are not foreseeable which may occur during my participation.*

*If illness, injury or accident occurs requiring immediate medical attention, I or my parent/guardian if I am a minor, authorize sponsoring representatives to obtain necessary medical treatment for my condition.*

*I have read this form and understand that there are inherent risks associated with any physical activity and recognize it is my responsibility to provide accurate and complete health//medical history information. Furthermore, it is my responsibility to monitor my individual physical performance during any activity.*

**Participant**  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian**  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(Must be signed by Parent or Guardian if child is under 18 years of age)*

# Incentives

***Earn prizes for the healthy activities you complete!***

***(TENTATIVE INCENTIVE LIST-SUBJECT TO CHANGE)***

100	Wings Key Chain	2100	Nike Visor
200	Wings Thermal Mug	2200	Nike Socks
300	Wings Socks	2300	Nike Water Bottle
400	Wings Cap or Visor	2400	Sports Watch
500	Wings T-shirt	2500	Nike Towel
600	Wings Back Pack	2600	Nike Shorts
750	Wings Shorts	2750	Nike T-shirt
1000	Wings Hooded Sweatshirt	3000	Sweatshirt
1250	Wings Duffle Bag	3250	Wings Duffle Bag
1500	Wings Wind Pants	3500	Wings Wind Pants
1750	Wings Wind Jacket	3750	Wind Jacket
2000	Wings Dress Watch	4000	Dress Watch

## **Tentative Monthly Walk/Run Schedule**

***(Two walk/runs per month if available. Walk/Run locations & dates subject to change)***

JANUARY	Run Short/Run Long – 20 & 5K – Tulsa
FEBRUARY	Wings Invitational 2 & 1 Mi. – Tahlequah TBA
MARCH	Wish Lemons – 5 & 1K – Tulsa TBA
APRIL	Flower Power 5K – Muskogee TBA
MAY	Strawberry Festival 5K – Stilwell TBA
JUNE	Wings Invitational – 2 & 1Mi. TBA
JULY	Huckleberry Festival Run – 5 & 1K – Jay Mohawk 5000 – 5 & 1K – Tulsa
AUGUST	Sandblazer – 5K – Tulsa Ft. Gibson Run – 5 & 1K – Fort Gibson
SEPTEMBER	CN Holiday Run – 5 & 1K – Tahlequah Fit 4 Life – 5 & 1K – Muskogee
OCTOBER	Tulsa Zoo Run – 5K – Tulsa Care to be Aware- 5K- Tahlequah Tulsa Run 15, 5 & 3K – Tulsa
NOVEMBER	Turkey Trot – 10 & 5K – Tulsa TBA
DECEMBER	Garden of Lights – 5K – Muskogee Holiday Classic- 5K- Claremore

# **REQUIRED FORM- must complete and return**

## **Physical Activity Readiness Questionnaire (PAR-Q)**

Name \_\_\_\_\_ Sex \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone #: \_\_\_\_\_

Mailing Address \_\_\_\_\_

***What is a Par-Q? The Par-Q is a simple screening tool and necessary before beginning this exercise program. The purpose is to clear for exercise or refer for further screening. The objective is not diagnostic, but to determine risk: orthopedically, cardiovascularly and chronologically.***

**YES**      **NO**      *Please read each question carefully and check the appropriate answer.*

- |       |       |  |
|-------|-------|--|
| _____ | _____ | 1.) Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? |
| _____ | _____ | 2.) Do you feel pain in your chest when you do physical activity?  |
| _____ | _____ | 3.) In the past month, have you had chest pain when you were not doing physical activity?  |
| _____ | _____ | 4.) Do you lose your balance because of dizziness or do you ever lose consciousness?   |
| _____ | _____ | 5.) Do you have a bone or joint problem that could be made worse by a change in your physical activity?                              |
| _____ | _____ | 6.) Is your doctor currently prescribing medication for your blood pressure or heart condition?                                      |
| _____ | _____ | 7.) Do you have insulin dependent diabetes?  |
| _____ | _____ | 8.) Do you know of any other reason why you should not engage in physical activity?  |

➡ If you answered **“Yes”** to one or more questions, you ***MUST*** complete a physical examination with physician consultation, i.e. **LETTER TO PHYSICIAN** before becoming more physically active.

➡ If you answered **“No”** to all questions, you have reasonable assurance that you can safely increase your level of physical activity on a gradual basis. A physical examination is not required.

I have read, understood and completed this Par-Q form. I am aware that there are inherent risks associated with any physical activity and recognize that it is my responsibility to provide accurate health and medical history information.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

(Must be signed by Parent or Guardian if child is under 18 years of age)



If you answered, "YES" to any questions on the PAR-Q please have your physician complete this form after a physical examination. This form must be turned in to Healthy Nation before full membership to Wings is granted. A copy of the physical exam is not required.

# Letter to Physician

Dear Physician:

Your patient \_\_\_\_\_, wishes to become a member of the Wings Physical Activity Program. This self-paced program involves progressive resistance training, flexibility exercises, and a cardio-vascular routine, increasing in duration and intensity over time.

After completing a Physical Activity Readiness Questionnaire (PAR-Q) and identifying a medical condition, we agree to seek your advice before participation in this physical activity program.

A physical examination is required, so please make recommendations or restrictions that are appropriate for your patient.

Thank you.

Please check one:

	<i>I am not aware of any contradictions toward applicant participation in this physical activity program.</i>
	<i>The applicant should not engage in the following activities:</i>
	<i>I recommend the applicant not participate in this physical activity program.</i>

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name (print): \_\_\_\_\_

Clinic/Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**REQUIRED FORM- must complete and return**

## **PHOTO/MEDIA RELEASE**

I, \_\_\_\_\_, give permission for CHEROKEE NATION  
(Parent/Guardian Signature)

HEALTHY NATION WINGS Program and persons acting for or through them, the right to use, reproduce, assign and/or distribute photographs, films, video tapes and/or sound recordings of myself or my child for use in materials they may create for the purpose of promotion.

\_\_\_\_\_  
*Signature of Participant*

\_\_\_\_\_  
*Date*

(Must be signed by Parent or Guardian if child is under 18 years of age)

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Date*

## **Notice of Health Information Practices**

Cherokee Nation Healthy Nation Wings Program

Participant Name: \_\_\_\_\_

I have been provided an opportunity to review and have a copy of the **Notice of Health Information Practices** of the Cherokee Nation Health Service.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

(Must be signed by Parent or Guardian if child is under 18 years of age)

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

## **Cherokee Nation Health Services Notice of Health Information Practices**

*This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

### **Understanding Your Health Record/Information**

Each time you visit a Cherokee Nation Health Services facility, a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment.

### **Your Health Information Rights**

The information which is contained in your health record belongs to you. However, the actual file itself and the medium it is written on belong to the Cherokee Nation Health Services.

You have the right to request a restriction on certain uses and disclosures of your information and to receive confidential communications concerning your medical condition and treatment.

You have a right to obtain a paper copy of this notice of information practices.

You have a right to inspect and receive a copy of your health record (excluding some records such as behavioral health and abuse records which are exempt from disclosure).

You also may correct inaccuracies or amend your health record and obtain an accounting of disclosures of your health information.

You have a right to request communications of your health information by alternative means or at alternative locations and to revoke your authorization to use or disclose health information except to the extent that action has already been taken.

### **Our Responsibilities**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

If you request a restriction to your medical records, we must notify you if we are unable to agree to the requested restriction.

We must accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in laws or regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

## **Examples of Disclosures for Treatment, Payment and Health Operations**

### ***We will use your health information for treatment.***

Information in your health record may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Information may be provided to pharmacists about other drugs you are taking to identify potential interactions.

You may be required to sign-in for services and your name may be called in the waiting room or over the loudspeaker in order to let you know that the staff member is ready to see you.

### ***We will use your health information for payment.***

Your health information may be used to seek payment from Medicare, Medicaid, grant programs (such as the CDC Breast and Cervical Cancer Detection Program), Cherokee Nation sponsored programs, private insurance or other sources of coverage such as an automobile insurer, or a person you are suing for injuries. These payers may request and receive information on dates of service, the services provided, and the medical condition being treated.

### ***We will use your health information for regular health operations.***

Your health information may be used as necessary to support the day-to-day activities and management of Cherokee Nation Health Services. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

We may disclose your health information to medical students working within our facilities and to business associates who perform services for us, such as an outside laboratory that performs certain tests for our patients.

We may disclose your health information to internal and external auditors, accreditation surveyors, and tribal, state and federal employees acting within the scope of their official duties.

***Notification:*** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

***Communication with family:*** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

***Correctional institution:*** If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

***Criminal Activity and Other Reports to Law Enforcement:*** We may disclose health information for law enforcement purposes as required by law or in response to a valid court order. For example, we must report drug overdoses, gunshot wounds, knife wounds, child abuse and elder abuse.

Under federal and state laws, we may disclose your health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend a fugitive, suspect, or material witness.

When a healthcare worker is a victim of a crime or when a crime occurs on our premises, or in an emergency, we may disclose information to law enforcement to assist in identifying and locating the perpetrator.

We may also report circumstances pertaining to victims of a crime, medical emergencies and death from criminal conduct.

***Food and Drug Administration (FDA):*** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

***Funeral directors, medical examiners and coroners:*** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

***Homeland Security:*** We may disclose health information as required by the Homeland Security Act.

***Organ procurement organizations:*** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

***Public health:*** Your health information may be disclosed to public health agencies as required to by law. For example, we may disclose information regarding communicable diseases to public health agencies such as the state health department. We may also disclose immunization information to schools and daycare.

***Research:*** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

***Workers compensation:*** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation.

#### **Additional Uses of Information**

***Appointment reminders and patient recall.*** Your health information will be used by our staff to remind you of an appointment or to contact you if you need to return earlier than scheduled. We may send you a postcard or letter, or may leave a message on your home answering machine or with your emergency contact or message phone.

***Information about treatments.*** Your health information may be used to send you information that you may find interesting on treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

#### **Other Uses and Disclosures**

Other uses and disclosures require your authorization.

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

#### **Requests to Inspect Protected Health Information**

You may generally inspect or receive a copy of the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the medical records department. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

#### **Federal Privacy Laws**

This Notice of Information Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws which also apply including the Freedom of Information Act, the Privacy Act, and the Alcohol, Drug Abuse, and Mental Health Administration Act. These laws have not been superseded and have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

#### **Complaints**

If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns to:

**Cherokee Nation Health Services**

**ATTN: Privacy Officer**

**PO Box 1069**

**Tahlequah, OK 74465**

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also file a complaint with the Senior Director of the facility where your record is kept, or with the Health Executive Director.

You will not be penalized or otherwise retaliated against for filing a complaint.

#### **Effective Date**

This notice is effective April 13, 2003.

#### **For More Information or to Report a Problem**

If have questions and would like additional information, you may contact the Health Privacy and Compliance Officer at (918) 456-0671 extension 2529.

# Activity Log

Name: \_\_\_\_\_

Week of: *Monday*, \_\_\_\_\_ to *Sunday*, \_\_\_\_\_

**Point System:** 1-2 days a week = 1 point, 3-4 days = 3 points, 5 or more days = 5 points

<i>Categories</i>	<i>Circle days of participation</i>
<b>1.) Running or Walking:</b> <i>(Minimum – 1 mile daily)</i> <i>Includes treadmill.</i>	M Tu We Th Fr Sa Su _____ <b>Points</b>
<b>2.) Strength Training:</b> <i>(Minimum – 30 minutes daily)</i> <i>Machine/free weights or other strength training exercises.</i>	M Tu We Th Fr Sa Su _____ <b>Points</b>
<b>3.) Other Fitness Activities:</b> <i>(Minimum – 30 minutes daily)</i> <i>Activities may include: aerobics, biking, basketball, swimming, etc.</i>	M Tu We Th Fr Sa Su _____ <b>Points</b>
<b>4.) Eat at least five servings of fruits and vegetables a day:</b> <i>* Fruits: not as sweetened juices or desserts. Vegetables: not with high caloric dip, salted or fried.</i>	M Tu We Th Fr Sa Su _____ <b>Points</b>
<b>5.) Read an article or attend a presentation on exercise, nutrition or health topics:</b> <i>* Sources: books, pamphlets, magazines, journals, web sites, seminars, conferences, etc.</i>	M Tu We Th Fr Sa Su _____ <b>Points</b>

**Add Total Points Here.** \_\_\_\_\_  
*(Use "Point System" to calculate)*



- The *Honor System* applies on each category and minimum guidelines must be met.
- Turn in Activity Logs each Monday to receive credit (via: fax, mail, or e-mail).
- All points received will be placed in a database for accurate record keeping.
- Call Healthy Nation periodically for updates on points and incentives earned.
- **Healthy Nation will not accept any log sheets over two months.**

**Phone Number: 1-800-850-0298**

**Fax Number: 918-458-6224**

**Mail: Cherokee Nation/Healthy Nation Program**

**Attn: WINGS**

**P.O. Box 948**

**Tahlequah, OK 74465-0948**

# Community Volunteerism

## The Gift of Giving

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- Each month, Wings members may volunteer in a community service project or event (of choice) and earn 20 additional points.
  - Examples may include: school functions, church projects, youth and elderly programs, tribal events or other community volunteer needs.
  - Employment duties, job responsibilities, or any form of payment that is received for time and service, will not be considered volunteerism.
  - *Community Volunteerism* is optional and if interested, return this form to Healthy Nation Wings program after volunteer service is performed. **Healthy Nation Wings will not accept any volunteer point forms over two months.**
  - Do not add *Community Volunteerism* points to your *Weekly Log* form (turn in separately).
  - No more than 20 additional points can be earned each month.
- 



**Yes, I volunteered in a community service project or event.**

*Please add 20 additional points to my Wings point total.*

Circle month:    Jan.        Feb.        Mar.        Apr.        May        June  
                         July        Aug.        Sept.        Oct.        Nov.        Dec.

Wings Member Name \_\_\_\_\_

Community Service Project/Event \_\_\_\_\_

Date of Project/Event \_\_\_\_\_

Coordinator  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**Phone Number: 1-800-850-0298**

**Fax Number: 918-458-6224**