

HEALTH EDUCATION EVENT REQUEST FORM

(Please Print)

Date: / /

REQUESTOR INFORMATION

Last name:		Primary phone no.:	Alternate phone no.:	
First:		()	()	
Email Address:				
Name of worksite, group, or agency you represent:			Phone no.:	
			()	
Address:				
P.O. Box:	City:	State:	ZIP Code:	

EVENT INFORMATION

Name:				
Date:	Time:	<input type="checkbox"/> AM	<input type="checkbox"/> PM until	<input type="checkbox"/> AM <input type="checkbox"/> PM
		Set-up Begins:	<input type="checkbox"/> AM	<input type="checkbox"/> PM

Address:		
City:	State:	ZIP Code:

Name of contact person on day of event:	Phone no: ()
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TYPE OF PROGRAM REQUESTED (check preference)

<input type="checkbox"/> Presenter	<p>Short presentation about a health topic conducted at your event.</p> <p>Specific Health Topic: _____</p> <p><input type="checkbox"/> Check if projector & screen provided <input type="checkbox"/> Check if computer available <input type="checkbox"/> Check if WiFi available</p>
<input type="checkbox"/> Exhibitor	<p>Table with health education material or interactive booth at your location, staffed by a Health Department employee(s) to answer questions and distribute educational materials.</p> <p><input type="checkbox"/> Check if table(s) provided <input type="checkbox"/> Check if electric outlet available</p>
<input type="checkbox"/> Special Requests	<p><input type="checkbox"/> HIV Testing <input type="checkbox"/> STD Screening <input type="checkbox"/> Contraception Counseling (Private & confidential 5x5 sqft room with chairs and close access to bathroom required)</p> <p><input type="checkbox"/> Carbon Monoxide Screening (Only for smokers to check CO levels)</p> <p><input type="checkbox"/> Clinical Breast Exam (Only for age 40-60) (Private & Confidential 10x10 sqft room with chairs required)</p> <p><input type="checkbox"/> HCHD Healthmobile (4-pronged outdoor outlet required) Proposed use: _____</p>

INFORMATION REQUESTED (check all that apply)

<ul style="list-style-type: none"> <input type="checkbox"/> Addictions/Alcohol/Drug Abuse <input type="checkbox"/> Aging <input type="checkbox"/> Cancer Programs <input type="checkbox"/> Children <input type="checkbox"/> Emergency Preparedness/Readiness <input type="checkbox"/> Environmental Health (Well & Septic, Community Hygiene, Food Protection, Tanning Facilities Program) <input type="checkbox"/> Family Planning (birth control methods etc.) 	<ul style="list-style-type: none"> <input type="checkbox"/> HIV-AIDS Prevention Materials & Screening Form <input type="checkbox"/> Immunizations (child, teen & adult) <input type="checkbox"/> Smoking Cessation/Clean Indoor Air Act <input type="checkbox"/> Teen Health <input type="checkbox"/> WIC <input type="checkbox"/> Other (please list) <p>_____</p> <p>_____</p>
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EVENT DETAILS

Purpose of Event:

Target Audience (check all that apply)

<input type="checkbox"/> Infant-Preschool (0-5)	<input type="checkbox"/> Teen (14-17)	<input type="checkbox"/> All Ages/Families
<input type="checkbox"/> Children (6-10)	<input type="checkbox"/> Adults (18-39)	<input type="checkbox"/> _____
<input type="checkbox"/> Preteen (11-13)	<input type="checkbox"/> Adults/Seniors (40+)	

Is this the first year of the event? Yes No, how many years? _____

How/where is event being promoted?

Is this event open to the general public? Yes No

Anticipated attendance number? _____ Past attendance number (if applicable)? _____

What other "health" agencies are attending?

PLEASE SUBMIT FORMS TO: askhealth@howardcountymd.gov via email or via fax to 410-313-5961

Please note that the Howard County Health Department and its staff and contractors will *do their best* to accommodate your program, date, and time requests, however, this form does not signify a contract or confirmation for products or services from the Howard County Health Department.

FOR HEALTH DEPARTMENT PROGRAM USE ONLY			
OUTCOMES	Final Event Info:	Event date: _____	Event time: _____
	Healthmobile Requests:	<input type="checkbox"/> Central Services contacted (through GLPI) for reservation/availability Date contacted: _____	<input type="checkbox"/> Check if healthmobile available with driver
	HCHD Employees Contacted:	Date: _____	Name: _____
		Date: _____	Name: _____
		Notes: _____	
	HCHD Employees Attending:	Name: _____	Bureau/Supervisor approving employee's time (attach email): _____
		Name: _____	
		Name (alternate): _____	
		Name (alternate): _____	
	Approved:	Supervisor: _____ Date: _____	Bureau Director: _____ Date: _____
Number of people educated by HCHD: (Attach sign-in list)			
Number of event attendees: (Attach event requestor email for accurate number)			