2025 ProKids Primary Care Provider Form

Indiana University Health

Instructions:

- 1. Complete all participant information, including email, and sign the form.
- 2. Visit your health care provider for a biometric screening and take this form.
- 3. Ask your provider to complete the Biometric Information section using results obtained between 2/1/2025 and 6/1/2025 and sign the form.
- 4. Submit form once, using one method listed below. Forms must be submitted by 6/1/2025. Forms received after the deadline will not be accepted.
 - a. Preferred Method: Securely upload online at https://www.totalwellnesshealth.com/gravity-landing/prokids-pof-online-upload/
 - b. Fax securely to 402-939-0458.
 - c. Mail to Total Wellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127. Forms must be received by 6/1/2025. Please allow time for mailing.
- 5. Within 5 business days of form submission, a confirmation email will be sent to the email listed below. If a confirmation email is not received after 5 business days, please resubmit your form.

Participant Date of Birth: (mmoddyyyy) Last 4 Digits of SSN: Primary Phone Number: Email: (Required to provide confirmation of form receipt.) Are you currently pregnant or up to 12 months postpartum? O Yes O No Are you currently pregnant or up to 12 months postpartum? O Yes O No BIOMETRIC SCREENING INFORMATION Date of Screening: (mmodd/yyyy) Blood Pressure: Physician Printed Name: Physician Phone Number: Physician Phone Number: Physician Phone Number: Physician Phone Number: Physician Printed Name: Physician Phone Number: Physician Phone Number: Physician Printed Name: Physician Phone Number: Physician Ph	PARTICIPANT INFORMATION Participant First Name:	Darticipant Last Name:	
Email: (Required to provide confirmation of form receipt.) Gender: O Maile O Female Have you fasted for at least 9 hours? (No food. Only water permitted.) O Yes O No Are you currently pregnant or up to 12 months postpartum? O Yes O No BIOMETRIC SCREENING INFORMATION Date of Screening: (mmiddlyyyy) Blood Pressure: Height: Weight: Waist: / / / / Declay of the state of the s	Participant First Name:		
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