Solanco School District

Wellness Verification Form - 2025 Discount

(Eligibility for 2025 Employee Share of Healthcare Premium Reduction)

1 Health Screenings/Biometrics

Knowing and tracking your numbers gives you the power to make choices that will help you maintain your overall health for a lifetime. Medical tests and screenings can help you to find problems early, when they are easier to remedy. Regular visits with your healthcare provider can help to identify steps that are important to protect your health.

Solanco will again be offering confidential onsite screenings during 2024 at no charge to you through Penn Medicine LG Health. Watch for notices of these events. You will receive the following health screenings:

Blood Pressure	Glucose (Blood Sugar)
Cholesterol Lipid Panel	Body Mass Index (BMI)

These Screenings can also be obtained from your own physician or by scheduling an appointment at a Penn Medicine LG Health facility. The screenings can be completed any time during the 2024 calendar year and the Penn Medicine LG Health **Provider Screening Form** (next page) must be completed and returned to the email/mailing address at the bottom, to qualify for the discount. Please complete the information below to verify the screenings were completed.

Date Completed_____

Choose One:

- **Screening obtained from Physician Office**_____
  (Provider Screening Form must be completed by Physician and returned to Penn Medicine)
- **Screening obtained from School Site**_____
- **Screening obtained from Penn Medicine Site** _____

2 Flu Shot

Flu season typically begins in the fall and peaks in January or February. Take action against the flu by getting immunized. Vaccination is the best protection against the flu. Seasonal flu vaccines have a very good safety track record. For this program, only employees and covered spouses are required. Consult your physician for any other family member/dependent flu shot needs.

Solanco offers the flu vaccine each year. You can also get this vaccine through your personal doctor or local pharmacy. This vaccine may be obtained at any time during the 2024 calendar year and verification forwarded to the Business Office by December 9, 2024, to satisfy the requirement.

Date Completed_____

Flu shot obtained from Physician Office_____**(Please have physician sign)**

Name of Physician (printed)_____

Flu shot obtained from other than Physician Office_____**(Please provide documentation)**

This form should be submitted to the Business Office, along with the medical provider's receipt, as proof the above procedures were completed.

This form is for (please circle) Employee Employee's Spouse

Employee Name (please print) _____

Wellness Verification Form NOT needed if obtaining health screening and flu shot from District onsite clinics.

Penn Medicine
Lancaster General Health

PROVIDER SCREENING FORM

please print

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL ____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ DATE OF BIRTH _____

EMAIL _____ PHONE _____

EMPLOYER NAME _____

By signing this form, I know that:

1. I am consenting to participate in the voluntary employee wellness program.
2. My health information may be used and disclosed as described in the EEOC Notice Regarding Wellness Program. I have been provided or have previously received a copy of the EEOC notice.
3. Lancaster General Health, Lancaster General Hospital, and any other groups associated with this wellness program, their affiliates, directors, officers, employees, successors and assigns, are released from any liability arising from or in any way connected with this program or the results derived therefrom.
4. I am responsible to pay any fees charged to me by my provider to have this form completed.
5. My health information may be used and disclosed as described in the Lancaster General Health Notice of Privacy practices. A copy of this can be provided upon request.

Signature _____ Date _____

This section is to be completed by a Health Care Provider or you may attach your test results.

HEIGHT Feet ____ Inches ____

WEIGHT (lbs) _____

BMI _____

WAIST CIRCUMFERENCE _____

BLOOD GLUCOSE _____
(fasting)

LDL CHOLESTEROL _____

HDL CHOLESTEROL _____

TRIGLYCERIDES _____

TOTAL CHOLESTEROL _____

BLOOD PRESSURE _____

I declare I have examined this individual and to the best of my knowledge, the results provided are true and correct.

Provider Signature _____ Exam Date _____

Provider Name (print) _____ Practice _____

RETURN THIS FORM BEFORE THE END OF THE WELLNESS PROGRAM ELIGIBILITY PERIOD

Email: LGHealthWellness@pennmedicine.upenn.edu
Secure Fax: 717.544.3504
Mail: Corporate Wellness | 1097 Commercial Avenue | PO Box 3555 | Lancaster, PA 17604-3555