Hoʻopōmaikaʻi Jumpstart Program
PARTICIPANT REGISTRATION

Name: _____ Age:_____ Gender: M or F

Address:_____

Email:_____ Best phone number to reach you at:_____

Primary care doctor:_____

Emergency contact person:_____

Relationship to participant:_____ Phone number:_____

Liability Acknowledgement Form

INFORMED CONSENT AND RELEASE FROM LIABILITY

I understand that my participation in the Hoʻopōmaikaʻi Jumpstart Program is strictly voluntary. I understand that I should consult with my physician before, during, and after I participate in this program, particularly if I am a diabetic and use medication to control my blood glucose levels. I understand that I will need to personally ensure I monitor my blood glucose levels very closely and promptly inform my doctor of any changes, in order to prevent serious harm and potential hypoglycemic shock. I will not, nor will anyone acting on my behalf, hold Hoʻopōmaikaʻi, or any of its agencies, officers, agents, or employees, responsible for any injuries that might occur from my participation in this program.

I acknowledge that I have read and understand this Liability Acknowledgement Form and I am freely and voluntarily signing it.

PARTICIPANT SIGNATURE:_____

DATE:_____

FOR PROGRAM STAFF USE ONLY:

Date of program:_____ Baseline BP:_____ Post BP:_____ Pre Wt:_____ Post Wt:_____

Ht:_____ BMI:_____ Baseline labwork date:_____ Post-labwork date:_____

Hoʻopōmaikaʻi Jumpstart Program
MEDICAL CLEARANCE FORM

Dear Doctor:

Your patient _____ _____ wishes to take part in a health program (Hoʻopōmaikaʻi Jumpstart Program). This program involves 10-days of plant-based meals (no animal food products) and encourages participation in daily, low to moderate-intensity exercise activities (including swimming, walking, stretching, and low-impact aerobic activity). Pre- and post-laboratory bloodwork assessing his/her lipid profile is recommended to measure any health changes that may occur and provide motivation to the patient in adhering to the program.

Based on your patient's medical condition(s), please advise in setting limitations for this patient. By completing this form, you are not assuming any responsibility for our program. Please identify any recommendations or restrictions for your patient below.

Physician's Recommendations

	She/he may participate fully in the Jumpstart Program, without dietary or activity restrictions or limitations.
	She/he may participate fully in the Jumpstart Program, with the following restrictions or limitations:
	Dietary restrictions/allergies:
	Activity restrictions:
	Other restrictions:
	She/he may not participate in the Jumpstart Program

Physician's signature	Date
Physician's name (print)	
Phone number:	

Patient's Consent and Authorization

I consent to and authorize my physician to release to the Hoʻopōmaikaʻi Jumpstart Program, health information concerning my ability to participate in the program and copies of my pre- and post-laboratory bloodwork. I understand this consent is revocable except to the extent action has already been taken. Further disclosure or release of my health information is prohibited without my specific written consent to whom it pertains.

Member's signature	Date

Hoʻopōmaikaʻi Jumpstart Program
NOTE TO INTERESTED APPLICANTS

Acceptance into the program is dependent on space available and medical clearance for participation in the program. If interested in participating, please submit the registration packet first. Once the packet is received, you will be contacted if you have been accepted into the program and then requested to submit payment, if accepted.

Submit your completed registration packet:
Via email: hjsprogram@outlook.com
In person: Hoʻopōmaikaʻi Jumpstart Program medical coordinator (Dr. Leon Matsuo)

Questions? Please contact us at:
hjsprogram@outlook.com
808-323-3317

PARTICIPANT CHECKLIST

	ONE MONTH BEFORE PROGRAM BEGINS
	Complete Jumpstart Registration Packet
	- Registration and liability form
	- Medical clearance form
	Obtain 2 laboratory bloodwork requisitions from your physician
	Submit payment (in the form of cashier's check or money order) and completed registration packet*
	ONE WEEK BEFORE PROGRAM BEGINS
	Get your laboratory bloodwork done at the laboratory indicated (Clinical Labs of Hawaii or Diagnostic Laboratory Services)
	DAY BEFORE PROGRAM BEGINS
	Complete the Jumpstart Shopping Tour (as scheduled)
	Purchase food items listed on your Jumpstart Shopping List
	Attend orientation dinner
	DURING THE PROGRAM
	Meet for dinner and health talks nightly (see program calendar)
	Participate in at least one exercise activity daily (see program calendar)
	DAY AFTER THE PROGRAM
	Get your laboratory bloodwork done at the laboratory indicated