The Wings Fitness Program is a program designed to promote the importance and awareness of regular physical activity, health education, and nutrition for a healthier lifestyle. This program is free and open to the public. You must reside in the Cherokee Nation service area to be a member.

What Cherokee Nation/Healthy Nation provides for you...

- Provide free registration for 21-28 selected walk/runs throughout the year.

What you as a Wings Member will provide for us...

- Attend the walk/runs throughout the year. You must pre-register for each race. Healthy Nation does not accept any race day registration. Healthy Nation also keeps track of race attendance. If you miss 3 races (that you sign up for) throughout the calendar year (January-December), you will forfeit your race privileges for the next 12 months. You become "inactive" by not attending a race for 6 months consecutively. At the point of “inactive” you must provide updated contact information if anything has changed and if your health has changed, you must submit a new Wings application along with a letter from your doctor giving the okay for you to participate in physical activity (see page 4 of this application).

***Important:*** You must be accepted as a Wings member before you can start entering the Wings sponsored runs. Please allow up to two weeks for processing Wings application. Please do not submit a race form with your Wings application. Thank you.

Please fax application and race forms to (918) 458-6224 or (918) 458-4466

Questions?

- Contact Trina Jackson trina-jackson@cherokee.org 918) 207-3913 or

- Julie Kimble julie-kimble@cherokee.org (918) 207-4906
Required Form – Must Complete and Return
INFORMED CONSENT

Please print legibly

Name: __________________________________________________________

Mailing Address: ______________________________________________

(Town) (County) (Zip)

Age: _____ Date of Birth: _______ E-mail: ________________________ □ Male □ Female

(Parents e-mail, if applicant is under age 18)

Student: □Yes □No School: __________________________ American Indian/Alaskan Native: □ Yes □ No

Tribal Affiliation(s):___________________________ t-shirt size: ____________ Veteran: □ Yes □ No

Home # (918) _______ Cell # (918) _______ work# (918) _______

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, authorized 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 the age of 18)

Notice of Health Information Practices
Cherokee Nation Healthy Nation Wings Fitness Program

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. (Please read pages 5 & 6 in this application)

Signature _______________________________ Date __________________

Parent/Guardian Signature _______________________________ Date __________________

(Must be signed by Parent or Guardian if child is under 18 years of age)
**REQUIRED FORM- Complete and Return**

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

Name____________________________________

**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: orthopedic, cardiovascular and chronological.

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)

**PHOTO/MEDIA INFORMATION**

Wings races are public events, be aware that sound recordings, photographs, and video devices may be present.
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 cardiovascular 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 of the following that apply.

<p>| | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>I am not aware of any contraindications toward applicant participation in this physical activity program.</td>
<td></td>
</tr>
<tr>
<td>The application should not engage in the following activities:</td>
<td></td>
</tr>
<tr>
<td>I recommend the applicant not participate in this physical activity program.</td>
<td></td>
</tr>
</tbody>
</table>

Physician Signature: ___________________________ Date: ___________________________

Physician Name (print): ___________________________

Clinic/Hospital Name: ___________________________

Address: ___________________________

Phone #: ___________________________
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. This information is often referred to as your medical record or “chart” and includes your billing information.

Your Health Information Rights

The information which is contained in your health record belongs to you. However, the actual file itself and the paper or other medium it is written on, belong to 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.

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.

You will be asked to sign an acknowledgment when you come to a Cherokee Nation Clinic or program. Our purpose is to make you aware of the possible uses and disclosures of your PHI and your privacy rights. Cherokee Nation Health Services will care for you even if you refuse to sign the acknowledgment. If you refuse to sign the acknowledgment, we will use and disclose PHI as outlined in this notice.

Disclosures Not Requiring Authorization: Cherokee Nation may use or disclose your PHI without your authorization for the following purposes:

Disclosures Not Requiring Authorization: Cherokee Nation may use or disclose your PHI without your authorization for the following purposes:

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 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.

Disaster: We may disclose PHI about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

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.

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

Health Oversight Activities: We may disclose PHI to a health oversight agency for activities necessary for the government to monitor the health care system, government programs, and compliance with federal law.

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

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to other lawful process.

National Security: We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Organ Procurement: 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.

Protective Services for the President and Others: We may disclose PHI to authorized federal officials so they may provide protection to the President and other authorized persons or to conduct special investigations.

Public Health: Your health information may be disclosed to public health agencies as required 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.

Serious Threat to Health or Safety: We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

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.

Uses and Disclosures Requiring 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 complaint or if you have questions and would like additional information, you may contact the Health Privacy and Compliance Officer at (918) 453-5529.

To file a complaint with the Secretary of the Department of Health and Human Services, contact:

U. S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
HHS.mail@hhs.gov

Effective Date: This notice is effective January 1, 2006.

For More Information or to Report a Problem
If you have concerns and would like additional information, you may contact the Health Privacy and Compliance Officer at (918) 453-5529.
Wings Schedule 2020

*All races listed below are free to Wings members.*

Races, dates and locations are tentative

<table>
<thead>
<tr>
<th>DATE</th>
<th>NAME OF RACE</th>
<th>LOCATION</th>
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<tbody>
<tr>
<td>1. March 28</td>
<td>Superhero 5K</td>
<td>Sallisaw</td>
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<tr>
<td>2. April 4</td>
<td>Grand Dam 5K &amp; 10K</td>
<td>Langley</td>
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<tr>
<td>3. April 11</td>
<td>Happy Hills 5K</td>
<td>Tahlequah</td>
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<tr>
<td>4. April 18</td>
<td>Lake Vian Trail Run</td>
<td>Vian</td>
</tr>
<tr>
<td>5. April 25</td>
<td>CC Camp 5K &amp; Fun Run</td>
<td>Stilwell</td>
</tr>
<tr>
<td>6. May 2</td>
<td>Run Jack Run PAAS 5k &amp; Fun Run</td>
<td>Vinita</td>
</tr>
<tr>
<td>7. May 9</td>
<td>Run for the Berries</td>
<td>Stilwell</td>
</tr>
<tr>
<td>8. May 16</td>
<td>5K Run for Wellness – Kay Lane</td>
<td>Muskogee</td>
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<tr>
<td>9. May 23</td>
<td>Isaiah Sapp Memorial Run</td>
<td>Kenwood</td>
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<tr>
<td>10. May 30</td>
<td>RISE Shelter 5K</td>
<td>Ft. Gibson</td>
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<tr>
<td>11. June 6</td>
<td>Beat the Heat 5K (evening)</td>
<td>Salina</td>
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<tr>
<td>12. June 20</td>
<td>Big Red Splash and Dash 5k &amp; Fun Run</td>
<td>Ft. Gibson</td>
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<tr>
<td>13. July 4</td>
<td>Huckleberry Run</td>
<td>Jay</td>
</tr>
<tr>
<td>14. September 5</td>
<td>Cherokee Holiday Run</td>
<td>Tahlequah</td>
</tr>
<tr>
<td>15. September 19</td>
<td>5K Sunset Dam Run/Walk</td>
<td>Disney</td>
</tr>
<tr>
<td>16. October 4 (Sunday)</td>
<td>Jay Duathlon &amp; 5K</td>
<td>Jay</td>
</tr>
<tr>
<td>17. October 10</td>
<td>Hornet 5K &amp; Fun Run</td>
<td>Vinita</td>
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<tr>
<td>18. October 17</td>
<td>Nowata 5K &amp; Fun Run</td>
<td>Nowata</td>
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<tr>
<td>19. October 24 tentative</td>
<td>Mickey Mantle 5K</td>
<td>Spavinaw</td>
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<tr>
<td>20. November 7</td>
<td>Will Rogers Memorial 5k</td>
<td>Claremore</td>
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<tr>
<td>21. December 5</td>
<td>Ugly Christmas Sweater 5K</td>
<td>Hulbert</td>
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