Medical Clearance

LAST NAME:	FIRST NAME:	MIDDLE NAME:
DATE OF BIRTH:	SEX:	DATE OF MEDICAL CLEARANCE:

APPLICANT'S PARENT'S/GUARDIAN'S NAMES:		
HOME NUMBER:	MOBILE NUMBER:	EMAIL ADDRESS:

Doctor's Information

DOCTOR'S NAME:		TITLE/POSITION
HOME NUMBER:	MOBILE NUMBER:	PLACE OF PRACTICE:
HOW LONG HAVE YOU KNOWN THE APPLICANT?		ARE YOU THE FAMILY'S PHYSICIAN?

Does the applicant have any allegies? If yes, please identify

ALLERGENS:
SYMPTOMS:
MEDICATIONS:
EMERGENCY CONTACT:

Does the applicant have any medical conditions? If yes, please identify

MEDICAL CONDITION 1:
MEDICATIONS NEEDED (Including dosage, frequency, who may administer the medication, and side effects):
IMPACT OF THE MEDICAL CONDITION ON THE APPLICANT'S DAILY LIVING:

MEDICAL CONDITION 2:
MEDICATIONS NEEDED (Including dosage, frequency, who may administer the medication, and side effects):
IMPACT OF THE MEDICAL CONDITION ON THE APPLICANT'S DAILY LIVING:

Activites which the applicant must avoid

Does the applicant have all the required immunization for his/her age?
Please attach a copy of the applicant's most recent immunization records.

_____
Doctor's Signature over Printed Name

_____
Date