VRAJ Adult Retreat
Medical Clearance Form

(This form is to be completed by Physician)

(To be submitted with registration form)

Retreat Applicant Name: _____ DOB: _____

Diagnosis: _____

Allergy to Food or Medicine: _____

If yes, provide details (Mild/Moderate/Severe reaction, symptoms, meds given, etc.):
_____

Names of Medications taken regularly:
_____

Length of time and frequency of dosage: _____

Does the applicant need to carry any emergency medicine? Yes _____No_____

If yes, please explain: _____

Are there any physical or other restrictions? Yes_____ No____

If yes, what and for how long? _____

Explain the limitations if the applicant CANNOT perform all his/her daily duties independently (e.g. bathing, dressing, eating, walking, etc.): _____

I understand that Vraj adult retreat is in a rural area of Pennsylvania and there is no medically trained person available at Vraj.

I certify that the applicant is medically stable and physically fit to participate in physical activities at the retreat.

Additional Notes: _____

Printed Name of Physician: _____ Signature of Physician: _____

Date: _____ Emergency Contact Number: _____

Office Stamp: