VRAJ Adult Retreat
Medical Clearance Form

(This form is to be completed by a Physician)

(To be submitted with registration form)

Name: _____DOB:_____

Diagnosis_____

Allergy to Food or Medicine: _____

Name of medication _____

_____

Length of time and frequency of dosage: _____

Does he/she need to carry any emergency medicine? Yes _____No_____ if yes please explain

_____

Are there any restrictions? Yes_____ No____. If yes what and for how long?

_____

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

I certify that he/she applicant is medically stable and physically fit to participate in physical activities during the retreat.

Extra notes:

_____ _____ _____ Printed

Name of Physician Signature of Physician Date

Emergency Contact number: _____ Office Stamp