



Medical Clearance Form



Client information					
To be completed by family doctor/ nurse practitioner					
Please print clearly					
Last name:		First:		Middle:	
Home Community (Band)	Band Number (10 Digits)			Birth date: DD/MM/YY	Age:
				Sex:	
				<input type="checkbox"/> M	<input type="checkbox"/> F
Community Currently Residing in:			Health Card #:	Home phone #: ()	
Current Address			Province:	Postal Code:	
Are you this client's family doctor?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If NO, provide Name of Family Doctor:	

MEDICATION				
IF MORE SPACE IS REQUIRED ATTACH SEPARATE SHEET!!				
Please Indicate all if any medications that this client is currently taking, please included over the counter.				
Type of Medication	Dose	Times/day	Purpose	How long has this client been on this?
Please Confirm - this client is NOT on medicinal Marijuana (THC)			<input type="checkbox"/> YES, they are	<input type="checkbox"/> NO, they are not
Has this client been involved with IV drug use?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has this client been tested for	HIV?	RESULT	Hepatitis A B C	Result

MEDICAL CONDITIONS					
<input type="checkbox"/> Diabetes Type <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Migraines	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Epilepsy Last episode:	<input type="checkbox"/> Other
Conditions Stabilized?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain:	
Allergies:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergic to:		
Shows signs of TB Prior to Admission	<input type="checkbox"/> Yes <input type="checkbox"/> No	Test results:		Doctor:	
		Did this Client Receive Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phone #:	
		If Yes with what medication?		When:	
Has this Medical Changed in the Past year?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last Physical?	

SIGNATURE REQUIRED			
Name of Doctor (Please Print)	Involved with Client # of Days/Months/Yrs.	Office phone no.: ()	Office fax no.: ()

The above information has been completed by me (the health professional) and i verify all to be true. Completed at your office.

Doctor signature	Office Stamp	Date of Physical: DD/MM/YY

The Rising Sun has an inferred sauna, does this client have any limitations that would prevent this client from using the sauna equipment? Sweat lodge? Walking exercise? Physical Limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please explain: