



VRAJ Adult Retreat, 2018
Medical Clearance Form
(This form is to be completed by 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 rural area of Pennsylvania and there is no Medically trained person is available at Vraj.

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

Extra notes: _____

Printed Name of Physician

Signature of Physician

Date

Emergency Contact number: _____

Office Stamp