# Regular and Relapse Prevention Program
# Medical Clearance Form

| CLIENT INFORMATION (PLEASE PRINT) | | | | | |
|---|---|---|---|---|---|
| **TO BE COMPLETED BY FAMILY DOCTOR/NP/COMMUNITY HEALTH NURSE** | | | | | |
| Last name: | First: | Middle: | | | |
| Home Community (Band) | Band Number (10 Digits) | Birth date: DD/MM/YY | Age: | Sex: ❑ M | ❑ F |
| Community Currently Residing in: | Health Card #: | Home phone #: ( ) | | | |
| Current Address | Province: | Postal Code: | | | |
| Are you this client's family doctor? | ❑ Yes | ❑ 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? |
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| **Please Confirm - this client is NOT on medicinal Marijuana (THC)** | | | ❑ YES, they are | ❑ NO, they are not |
| Has this client been involved with IV drug use? | | | ❑ YES | ❑ NO |
| Has this client been tested for | HIV? | RESULT | Hepatitis A B C | Result |

| MEDICAL CONDITIONS | | | | | |
|---|---|---|---|---|---|
| ❑ Diabetes Type ❑ 1 ❑ 2 | ❑ Hypertension | ❑ Migraines | ❑ Heart Condition | ❑ Epilepsy Last episode: | ❑ Other |
| Conditions Stabilized? | ❑ Yes | ❑ No | Explain: | | |
| Allergies: | ❑ Yes | ❑ No | Allergic to: | | |
| **Shows signs Of TB Prior to Admission** | **❑ Yes** | **❑ No** | **Test results:** | **Doctor:** | |
| | | | **Did this Client Receive Treatment:** ❑ **Yes** ❑ **No** | **Phone #:** | |
| | | | **If Yes with what medication?** | **When:** | |
| Has this Medical Changed in the Past year? | ❑ Yes | ❑ 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 it all to be true.* *When was this 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 exercises? Physical limitations? | ❑ Yes ❑ No | Please explain: |