MARGARET'S PLACE PARTICIPANT'S MEDICAL ASSESSMENT

To be filled out by participant's physician or designated agent

Participant's Name: ___________________________________ DOB: _______________________

Doctor's name: ______________________________ Phone number:_____________________________

What is the participants medical condition?
Does the participant have any special activity needs or restrictions?
What therapies if any has the participant been involved in?
List any allergies:
Dietary restrictions:

MEDICATION (List all medications participant is currently taking)			
Medication Name	Dosage	Frequency	When taken

_______________________ _______________________ ____________

Physician Printed Name | Physician Signature | Date

_______________________ _______________________ ____________

Designated agent Printed Name | Designated agent Signature | Date