Note to Doctor

To whom it may concern:

Please fill out the enclosed form completely and sign it. You can attach the prescription list if you don't want to write in each prescription. Also kindly provide a print out of the following communicable diseases test result;

- ☐ Tuberculosis (TB)

The requested information and results can be mailed, hand delivered by patient/caregiver or mailed to us or emailed. If you have any questions please call or email us.

Margaret's Place

Adult Recreation and Wellness Center

PARTICIPANT'S MEDICAL ASSESSMENT

To be filled out by the **participant's physician.**

Participant's Name: _____ DOB: _____

Doctor's name: _____ Phone number:_____

What is the participant's 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:

Margaret's Place
ADULT RECREATION & WELLNESS CENTER

MEDICATION (List all medications participant is currently taking.)
_____ Initial here if you have attached a printed copy of the MEDICATION LIST.

Medication Name	Dosage	Frequency	Note

I have examined the individual named above and have completed the requested communicable disease screening. My findings show that their results are negative for TB. I have provided a copy of the test results. By signing below I certify that the above information is true. **Please provide negative test result documentation:**

_____ _____ _____

Physician Printed Name Physician Signature Date