



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 results;

- | | |
|--|--|
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Negative Covid Test |
| <input type="checkbox"/> Hepatitis B | |
| <input type="checkbox"/> Hepatitis C | |

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

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:



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 screenings. My findings show that their results are negative for COVID-19, TB, Hep panel, and HIV. 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