PHYSICIAN'S HEALTH EXAMINATION FORM

Participant's Name: _____

This form must be completed by a licensed physician **ONLY** if the participant will be bringing prescription medication to Marrowstone or has a chronic disability or health concern. If a participant brings prescription medication to Marrowstone and does not return this form completed by a physician, Marrowstone reserves the right to send the participant home without refund.

Height: _____ Weight: _____ BP: _____ Hct/Hgb: _____

Are there any allergies and/or diseases about which the staff should be aware? If so, please describe symptoms and indicate antidote:

General appraisal (please attach a separate page if necessary):

Are there any prescription medications this person should take while at Marrowstone? YES / NO

If yes, please indicate the medications, proper dosage(s), precautions and the reason(s) for the medication(s). Indicate which medications, if any, should be turned over to the Marrowstone administration for administration and safekeeping.

Recommendations and/or restrictions:
Swimming and diving: _____
Strenuous activity: _____
Other:_____

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is physically able to engage in Marrowstone activities, except as noted above.

Examining Physician: _____ Phone: _____

Physician's Signature: _____ Date: _____