Medical Clearance Form

Patient Name: ____

Diagnosis: __________________________ Date of diagnosis: ____________________

Is the patient currently on therapy: ____

Date or expected date of completion: ______________________________________

Is the patient ambulatory: ____

Are there any concerns: ____

Can the patient or family provide care for the patient on a vacation: _________

Medical Clearance: The patient listed above is approved with medical clearance to attend a Homes of Hope Getaway. We will contact the medical staff just prior to the trip date to make sure this approval is still valid.

Name and Title: ____

Phone: ____

Signature: ____

Date: ____

For Homes of Hope Purposes Only:

Received Final Medical Clearance: ___ yes ____no

Medical staff who approved clearance: ______________________________________

Date of Clearance: ____