MEDICAL CLEARANCE FORM

I, _____find_____

Provider **Patient's Name** **DOB**

to be medically stable and able to participate in the program for eating disorders. I have attached copies of a physical examination, CBC with Diff, Chem 6, Chem 12, Magnesium, UA, Toxicology screening, EKG, CPK, Amylase, B12, Folate, and TSH.

****If my patient is under 20 years of age I certify that their growth charts accompany this form.****

Please check the following statements as applicable:

- ☐ My patient has a documented medical condition that is best managed through a therapeutic diet (i.e. Diabetes Mellitus, Chronic Kidney Disease, etc.).
- ☐ My patient has a documented **food allergy** (i.e. Celiac Disease, peanuts, shellfish) that causes an autoimmune response that could lead to a life-threatening response.
- ☐ My patient has a documented **food sensitivity** that has been consistently reported over a span of five years or clinically tested (i.e. lactose intolerance) that can lead to gastrointestinal discomfort but that does not result in a life-threatening response.
- ☐ My patient has recently reported a **food sensitivity** (in the last five years) and there is no corroborating evidence for their reports. They do not indicate that this food causes a life-threatening response.

If a box was checked above, please elaborate:

_____

_____

_____

_____

Signature: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____

Please fax to 585.641.0286