CORE TREATMENT SERVICES INCORPORATED

MEDICAL CLEARANCE FORM

To be admitted to CORE Treatment Services, Inc, a Residential Substance Use Disorder facility, the individual must have medical clearance from a physician. Please observe and discuss with the individual the information below and complete this form.

Name:_____ DOB:_____

Date of visit:_____

Please indicate below (by checking the box) if the individual is free from the following communicable diseases:

- ☐ HEP A,B or C
- ☐ STD's
- ☐ SKIN INFECTIONS
- ☐ MRSA

Is the individual free of all withdrawal symptoms requiring medical attention?

- ☐ YES
- ☐ NO
- ☐ Explain:_____

Is the individual ambulatory without assistance?

- ☐ YES
- ☐ NO
- ☐ Explain:_____

Any other medical concern/diagnosis we should be aware of?

- ☐ YES
- ☐ NO
- ☐ Explain:_____

TB Test – PPD (CORE staff will take individual to have test read)

Date Placed:_____ Where Placed:_____ Signature:_____

Date Read:_____ Result:_____ Signature:_____

The following over-the-counter medications are approved for this patient to be given per package instructions unless otherwise indicated.
Please check the box to indicate approval.

- ☐ Acetaminophen 500mg, 1 – 2 tabs q 8 hrs PRN discomfort
- ☐ Ibuprofen 600mg q 6 hrs PRN discomfort
- ☐ Benadryl 25 – 50mg q 8 hrs PRN allergies
- ☐ Melatonin 3 – 10mg tabs PRN sleep
- ☐ OTC vitamins/supplements
- ☐ Acid Reducing Medications (PPIs)
- ☐ Cough Drops
- ☐ Triple Antibiotic Cream
- ☐ Athlete's Foot Powder
- ☐ Imodium
- ☐ Anti-fungal Cream
- ☐ Stool Softener
- ☐ Cold/Flu Medication
- ☐ Antacid/Tums

If the individual is prescribed any medication, please attach a signed prescription as we cannot administer medications without it.

Please contact CORE Treatment Services, Inc. if you have any questions regarding this form or allowance of medications.

_____ _____

Medical Professional Signature (MD or NP only) Date

_____

Name of Clinic/Hospital