WCCMT

West Coast College of MASSAGE Therapy

Medical Clearance Form

Patient Name: **Date of Birth:**

Examining Physician:

WCCMT requires all applicants registering into the Massage Therapy program to present this form to a qualified physician to provide third party medical clearance. This form must be completed in order for the applicant to meet WCCMT's medical requirements. Please complete the following assessments below.

Physical Health	**YES**	**NO**
Has/does the patient:		
Any recent injury, illness, or infectious disease?	☐	☐
Have a chronic or recurring illness/condition?	☐	☐
Ever passed out during or after a strenuous physical activity?	☐	☐
Ever had seizures?	☐	☐
Ever had high blood pressure?	☐	☐
Ever had back problems?	☐	☐
Ever had problems with joints (e.g. knees, ankles)?	☐	☐

Please explain if answered "yes".

Mental Health	**YES**	**NO**
Is the patient in good mental health?	☐	☐
Has the patient had any history of mental health illness?	☐	☐

Please explain if answered "yes".

Communicable Diseases	**YES**	**NO**
Does the patient have any form of communicable diseases?	☐	☐
Does the patient have any skin problems (e.g. allergies, rash)?	☐	☐

I declare that I have completed a full examination on the above patient and find him/her to be in good physical and mental health and to be free from any communicable diseases. I also certify that the medical assessment provided by me on this form is true and accurate to the best of my knowledge.

The above patient: ☐ *is* ☐ *is not* able to participate in the program.

Physician Name:

(printed) (signature)

Date: **How long have you known the patient?**