



**EDUCATION/SKILLS BUILDING INCENTIVE PROGRAM
MEDICAL CLEARANCE FORM**

BCCY
 SCY
 SCYC

Youth Name: _____

Client ID#: _____

This youth is under consideration to participate in an on-campus / off-campus skills building assignment and may be under the supervision of on-campus worksite supervisor _____ / employed at _____.

This youth is under consideration to participate in a on-campus / off-campus educational classes and will be under the supervision of facility personnel. It is necessary to establish that those participating in the **Education /Skills Building Incentive Program** do not have any physical or mental health conditions that may be adverse to self or others in the work environment. To assist us in this determination, you are being asked to answer the following:

Has this youth been tested for Tuberculosis?	Date Tested	Test Type	Results
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Skin Test <input type="checkbox"/> X-Ray <input type="checkbox"/> Sputum Culture	<input type="checkbox"/> Negative <input type="checkbox"/> Positive (explain in comments)

How would you describe the patient's general physical/mental condition and health from the statements below? (Use Comments section for explanations)

___ No physical/mental condition or health problem exists that would limit the youth's ability to work with or around others.

___ Physical/mental condition or health problem exists which would affect the youth's ability to work with or around others, with or without reasonable accommodation.

___ No medication regime exists which would hinder the youth's ability to work off-campus for a minimum of 6 hours to 8 hours per day.

Comments (Please use back of this form if additional space is needed)

Facility Medical Provider's Signature	Date	Examination Date
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c: Education and/or Skills Buildings Program Coordinator