Catch the New Jersey WAVE
WONDERFUL ADOLESCENT VENTILATOR EXCURSION

MEDICAL CLEARANCE FORM

ALL INFORMATION COLLECTED WILL
REMAIN PERSONAL AND CONFIDENTIAL

Dear Doctor,

Your patient, _____ , has applied to participate in WAVE, the NJ shore getaway for children who have tracheostomies, who are ventilator-dependent, or have specialized medical needs. Please refer to the informational brochure for details.

Please review your patient's application information (enclosed) for accuracy and completeness.

PATIENTS DIAGNOSIS (MEDICAL ISSUE)

Allergies: _____

Motion Sickness: _____

Recent Medical Problems: _____

Your patient should be medically stable to participate in WAVE. Of note, your patient may not be attending with his/her usual home caretakers, in order to foster independence and maturation. Participants will be cared for at the getaway by experienced professionals.

Do you believe that _____ is medically stable to participate in WAVE?

☐ Yes ☐ No

Comments: _____

To the best of my knowledge, the above information is correct.

Date: _____

Name: _____ Title: _____

Address: _____ City: _____ State: _____ Zip: _____

For additional questions or comments, please call the WAVE coordinating Physician:

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Pediatric Pulmonology
(609) 926-0962