

## Medical Release Letter

Date: \_\_\_\_\_

To The Physician of \_\_\_\_\_

\_\_\_\_\_ has registered for one of our programs, the format of which may present situations that initiate deep personal process. This program is designed for healthy individuals. An individual for whom it is inappropriate to explore stressful emotional situations should not enroll in the program. To support the well-being of each participant, we require that each participant confirm to us that he/she has not been hospitalized for a mental disorder within the past 5 years, or has not taken any psychotropic medications (which include anti-anxiety agents, anti-manic agents, antidepressants, psychostimulants, anti-panic medications and anti-psychotics), seizure disorder medications, or prescription sedatives within proscribed periods prior to taking this program. In the case of psychotropics classified as anti-psychotic, the proscribed period shall be two years. In the case of other psychotropics, seizure disorder medications, or prescription sedatives, the proscribed period shall be six months.

\_\_\_\_\_ has informed us that he/she is currently taking or has taken, within the proscribed period, psychotropic medications, seizure disorder medications, or prescription sedatives. He/she has represented to us that such medication was prescribed solely for a physical condition and not for any type of mental or emotional disorder. We cannot process his/her application to participate in our program unless you complete and return the attached form.

Thank you for your courtesy and cooperation.

Sincerely,

Your name and title here

\_\_\_\_\_

To: Your Name  
Your Title

From:  
Physician's Name \_\_\_\_\_  
Office Address \_\_\_\_\_

Telephone \_\_\_\_\_

Patient's Name \_\_\_\_\_

Medications (Current or within the past two years):

\_\_\_\_\_

This is to confirm that the condition for which \_\_\_\_\_ is being treated is wholly physical in nature and that the medications prescribed are for the alleviation of this physical condition. In my opinion, the above named patient has not suffered any mental or emotional disorder in the last two years. It is also my opinion that he/she has the physical and emotional health to permit the exploration of stressful situations.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**Policy Statement for Psychotropic Medications,  
Seizure Disorder Medications, Prescriptions,  
Sedatives/Hospitalizations for Mental Or Emotional Disorders**

Individuals who participate in an FBHS program may encounter situations that initiate deep personal process. Frequently, an individual who is on these certain types of medications or has been hospitalized for mental or emotional reasons cannot tolerate stressful emotional situations. It is recommended that enrollment in the program be postponed.

**Sample Policy:**

No individual can be a participant in the FBHS Workshop if he/she is or has been taking psychotropic medications, seizure disorder medications, or prescription sedatives during the school year or within proscribed periods prior to the school year. This includes psychotropic medications, seizure disorder medications, and sedatives prescribed to treat a mental or emotional disorder. Psychotropic medication includes anti-anxiety agents, anti-manic agents, anti-depressants, psychostimulants, anti-panic medication, and anti-psychotics.

In the case of psychotropics classified as anti-psychotic, the proscribed period shall be two years.

In the case of other psychotropics, seizure disorder medications and prescription sedatives, the proscribed period shall be six months.

If the medication was prescribed solely for a physical condition and not for any type of mental or emotional condition, the prospective participant must submit a physician's statement, using the Medical Release Form, attesting to this fact.

In addition, no individual who has been hospitalized for a mental or emotional disorder within the past five years will be admitted into the Program or permitted to continue in the Program.

**LIST OF PROHIBITED PSYCHOTROPIC MEDICATIONS:**

<i>6 Months</i>			<i>2 Years</i>
Adapin	Inapsine	Phenobarbital	Clozaril Compazine Haldol Loxitane Mellaril Moban Navane Prolixin Serentil Stelazine Thorazine Trilafon
Amitral	Klonopin	PMB200	
Anafranil	Librax	PMB400	
Asendin	Libritab	Prozac	
Atarax	Librium	Restoril	
Ativan	Limbitrol	Ritalin	
Butisol	Ludiomil	Serax	
Buspar	Mebaral	Seconal	
Celexa	Mepergan	Serayon	
Celontin	Mesantoin	Sinequan	
Cylert	Milontin	Surmontil	
Depekene	Miltown	Tegretol	
Depakote	Mysoline	Tofranil	
Desixtab	Nardil	Trancopal	
Diamox	Nembutal	Tranexene	
Dilantin	Neurontin	Tridione	
Desyrel	Norpramin	Valium	
Effexor	Pamelor	Versed	
Elavil	Paxil	Vistaril	
Endep	Paradion	Vivactil	
Etrafon	Parnate	Wellbutrin	
Eskalith	Peganone	Xanax	
Felbatol	Phenergan	Zarontin	
Hydroxyzine	Phenurone	Zoloft	