REVELATIONS OF FREEDOM MINISTRIES
MEDICAL/DENTAL POLICY

The following policy shall be adhered to by all students upon admission to the Revelations of Freedom Ministries. It is encouraged that each student who does not have an immediate medical emergency wait until they are transferred to the 2nd phase of ROFM.

A. I understand that all major medical problems shall be addressed prior to admission to the Revelations of Freedom Ministries (ROFM).

B. I understand that I must have a 30-day supply of any and all medications with a minimum of four refills on the prescribed medication prior to admission to the ROFM.

C. In the case of a medical emergency, the student will be taken to the nearest emergency room immediately.

D. I understand that if a student needs major medical attention, I may be released from ROFM for 30 days.

E. I understand that if I need blood tests, doctor's visits, physical therapy, eye exams, glasses or contacts, or any and all medical attention other than an emergency, I will be required to pay driving fees.

F. I understand that money will be taken from emergency fund to pay these fees. If I do not have money in my emergency fund, I will be required to pay for transportation costs before moving to the 2nd phase of ROFM.

Resident Printed Name: _____ Date: _____

Resident Signature: _____ Date: _____

Witness Printed Name: _____ Date: _____

Witness Signature: _____ Date: _____

INTAKE MEDICATION POLICY

If you have been prescribed any medication or medications for any ongoing condition or conditions, you must bring **at least a 30 day supply** of these medications.

Examples of the types of medications you should bring if you have been prescribed them:

-Asthma medications
-High blood pressure medicines
-Heart medications
-Insulin or other diabetes medications
-Medications for acid reflux or other gastrointestinal maladies

I, _____ have read the above information, and I understand that it is my
(Print name)
responsibility to provide my prescription medication. I understand it is not ROFM's responsibility to supply my meds. By signing this paper, I agree to the information above and will assume full responsibility for getting the medication needed before entering ROFM.

Resident Printed Name: _____ Date: _____

Resident Signature: _____ Date: _____

Witness Printed Name: _____ Date: _____

Witness Signature: _____ Date: _____