Medical Clearance Form

STUDENT Info

Name:_____

ID Number:_____

Date of 1st Clinical Rotation:_____

MEDICAL PRACTICE OFFICE Info

Name of Facility:_____

Address:_____

Phone Number:_____

MEDICAL CLEARANCE

☐ This student is in adequate physical and mental health to provide services in a direct contact clinical environment.

☐ This student presents concerns that may be a potential risk to the student or others. Please explain:_____

_____

_____

_____

ADDITIONAL COMMENTS

_____

_____

_____

_____

MEDICAL PRACTITIONER'S Info

Signature:_____

Printed Name:_____

Date:_____