

**ROXBOROUGH MEMORIAL HOSPITAL
SCHOOL OF NURSING**

MEDICAL CLEARANCE FOR ILLNESS FORM

All fields MUST be completed by a Physician or Physician Extender

Student Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Temp: _____ BP: _____

HR: _____ RR: _____ Pulse Ox: _____

Diagnosis: _____

- I acknowledge that the above-named individual is medically cleared to perform the duties of a student nurse in the classroom and clinical setting **with no restrictions.**

Date Cleared to Return: _____

Provider's Name: _____

Specialty: _____ State License #: _____

Street Address: _____

Telephone: _____ Fax: _____

Provider's Signature: _____

(include credentials)

Examination Date: _____

Health Care Provider
Seal/Stamp
Here