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**:** **_____**

Examination Date**:** **_____**

Health Care Provider Seal/Stamp Here