



KINGSBOROUGH COMMUNITY COLLEGE

HEALTH CENTER

STUDENT INJURY / ILLNESS FORM

TO THE STUDENT:

This form is to be returned by you to the college medical office, after having been filled out by your physician:

Student's Name _____ DOB: _____

Address _____ Home Telephone # _____

By signing, the student is providing release for KBCC to discuss her request with the Healthcare Provider completing the information on this page.

Student's Signature: _____ Date: _____

THE FOLLOWING IS TO BE FILLED OUT BY YOUR PHYSICIAN:

State of student's health: _____

Recommendations regarding college workload: _____

Will student be checked regularly at your office? _____

Is student able to attend off-campus clinical experiences and participate fully and without restriction in accordance with the KCC Nursing Department and clinical affiliates policies.?"? _____

Name of Physician (Print & Stamp)

Date

Signature of Physician