KINGSBOROUGH COMMUNITY COLLEGE ★ DREAMS BEGIN HERE ★ CUNY

HEALTH CENTER

Pregnancy report form

TO THE STUDENT:

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

Student's Name____________________________________ **DOB:**________________

Address____

Primary Telephone Number(s) ____

By signing this form, the student is providing release for Kingsborough Community College 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 OBSTETRICIAN:

State of student's health: ____

_ _

Expected date of delivery: ____

Recommendations regarding college workload: ______________________________

_ _

Will student be checked regularly at your office? ______________________________

Is student able to attend hospital affiliations and give medical care to patients? ______________________

______________________________ _______________ ________________________

Name of Physician (Print & Stamp) **Date** **Signature of Physician**

__________________________________ ______________________

Address **Telephone Number**