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

2001 Oriental Boulevard □ Brooklyn, NY 11235 □ Telephone 718 368 5684 □ Fax 718 368 5024
A College of The City University of New York