



**FITNESS FOR DUTY/HEALTHCARE PROVIDER STATEMENT**

**COMPLETED BY STUDENT: RELEASE OF INFORMATION**

Student Name: \_\_\_\_\_ Program: \_\_\_\_\_ Course: \_\_\_\_\_  
(First) (Initial) (Last)

Reported health condition: \_\_\_\_\_

I consent to the release of medical information requested with regard to the health condition referenced above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COMPLETED BY HEALTHCARE PROVIDER:**

Additional medical information for this individual is requested regarding the health condition referenced above. Please complete the appropriate section(s) below.

**COMMUNICABLE DISEASE STATUS**

Disease: \_\_\_\_\_

This individual is currently:

\_\_\_ Infectious/contagious and is not approved for attending school/clinical/hospital settings until \_\_\_\_\_.

\_\_\_ Non-infectious and is approved for attending school/clinical/hospital settings.

**Comments:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare Provider (print name): \_\_\_\_\_ Phone: \_\_\_\_\_