Allied Health and Nursing

Health Declaration Form

Student is to complete this form and return to the Program Director by the assigned deadline.

_____
Program

_____
Student ID #

_____, _____, _____
Last Name First Name Middle / Maiden Name

_____ _____ _____ _____
Address City State Zip Code

_____ _____
Home Phone Number / Cell Phone Number Email

Date of Birth: _____ / _____ / _____

Please Read and Sign Below

I certify that I have no known health conditions which would jeopardize my own or a patient's welfare and have no limitations which would restrict me from performing the customary duties of a health career student, as defined in my program-specific student handbook. If I have or develop an allergy, it is my responsibility

I understand that failure to sign this form or to provide the information requested in the Exposure and Immunity Requirements Form may cause a clinical site to refuse me for placement at their facility. The health career program does not guarantee an alternative facility placement. I also understand that if no alternative facility placement is available, I may be terminated from the health career program.

Signature: