M.A.P.T. Clinical Clearance Form

STUDENT INFORMATION

Insurance: Marsh Affinity Group
Seabury & Smith

Last name
First name
Birth date
Middle name or initial
Program: M.A.P.T.
Current date

Clinical clearance form Dates:

☐ 1st ☐ 2nd ☐ 3rd Hepatavax B

TB MMR C-Pox D/T Varicella

Medical Information *Address correspondence to:*

Last name First name

Address

City State or Province

Postal code

Home phone Day phone

Last name First name

Relationship

Address

City State or Province

Postal code

Home phone Day phone

OTHER EMERGENCY CONTACT

Name Relationship

Home phone Work phone

MEDICAL INFORMATION

Doctor Clinic

Address

City State or Province

Postal code

Clinic phone Dr. office phone

After hours phone

Allergies

Medical problems

Medication

NOTES

MD _____ Date _____

M.D. or NP Please sign off when completing students clinical clearance