



Elgin Community College

Health Professions Department
Health Release Form

_____ has my permission to continue in
(student name)

Class and clinical for _____ with no limitations.
(program)

Physician's Signature: _____

Date: _____

Physician's Name: _____

Address: _____

Phone Number: _____

Dr's Office Stamp: _____

Bright Choice. Bright Future.

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