PHYSICIAN'S STATEMENT

Student Name: _____ Sex: M or F

Date of Birth: _____ Date of Examination: _____

This student has the following problems that may impact the college/dormitory experience:

☐ None ☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

_____

Additional Diagnoses/Significant Health Conditions:

_____

_____

_____

Current Medications and Dosages: _____

_____

_____

☐ This student has a health condition that may require emergency action, e.g. seizures, or allergies.
Specify below: _____

_____

Physician's Statement: I have examined the above applicant and have found him/her in good health and free of any communicable diseases. If necessary I have described any additional conditions that may affect the applicant in the area below.

_____

_____

_____

_____

_____

_____

Physician's Signature: _____ Date: _____

Date of Examination: _____

Please attach a copy of the student's Immunization Record or send to one of the following:
Email: kmbc@kmbc.edu Fax: 1-888-742-1124
Mail: Office of Admissions, 855 HWY 541, Jackson, KY 41339