Exhibit B
HEALTH CERTIFICATION

Student/School Information

Student Name:_____

Address:_____

_____

Telephone:_____

*License #:_____

*License Expiration Date:_____

School:_____

Address:_____

_____

Course Name and Number:_____

_____

Faculty Liaison/Coordinator:_____

Telephone:_____

Practicum Dates:_____ through _____

Projected Education Experience Hours: _____

CPR Status:

Organization Supervisor/Preceptor Information

Supervisor/Preceptor Name: _____

_____

Title:_____

Dept.:_____

Telephone:_____

*License #:_____

*License Expiration Date:_____

_____

Project:_____

_____

CPR Status

Immunization Status Insert Date of Each Immunization or Completion	TB Evaluation Date Completed	Mumps	Rubella	Rubeola	Varicella Zoster	Hepatitis B Vaccine Date/Declination	Influenza Vaccine	COVID-19 Vaccine
***School Supervisor/Preceptor Name**								
Student Name								

*Information is necessary only if school supervisor/preceptor will be onsite during educational experience.

If an exemption was granted for medical or religious reasons for any vaccine, please indicate "Exemption" and the date it was granted.

I reviewed the vaccination information required for the Student and Supervisor/Preceptor noted above and affirm that the required vaccination documentation was presented to the School or the School has granted a medical or religious exemption for a vaccination. I also confirm Patient Rights was reviewed. I confirm I am authorized to sign this document on behalf of School.

_____

Print Name

_____ _____

Signature Date