



COLLEGE OF PROFESSIONAL STUDIES  
NURSING DEPARTMENT

STATEMENT OF RELEASE

Prior to participation in any clinical experiences, I understand that I must submit required health records, including a recent physical examination, proof of immunity to Measles, Mumps, Rubella, Varicella and Hepatitis B and additional immunizations, as required by clinical agency and university policy. I hereby authorize New Jersey City University Nursing Department to release my health information to clinical agencies upon their request and/ or to contact my Healthcare Provider for clarification of information. I understand requested information will be released on a need to know basis for the protection of my health, or the health of others.

I am aware that if during the course of the academic year my health status should change in a way that would impact my ability to perform in a clinical setting, I must notify the Chair of the Nursing Department. The need for additional clearance will be determined at that time.

Name: \_\_\_\_\_  
(print)

Student ID#: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_