PREGNANCY RELEASE FORM

NAME: ___________________________  GCID#: ___________________________

The above named person is medically clear to attend clinical experiences associated with the Nursing Program at Gordon College.

This release includes the student being able to:

1. Lift at least 20 pounds
2. Be on her feet for 8 – 12 consecutive hours.

Please list any required restrictions on the student’s activities.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signed: ________________________________________, MD or CNM

Office Address: ________________________________
________________________________________________________________________
________________________________________________________________________

Telephone Number: ________________________________

Date: ________________________________

I, ________________________________, authorize Gordon College Nursing Program to request and receive information related to my medical history from the listed physician or nurse midwife’s office.

Printed Name: ________________________________________

Signed: ________________________________________
Gordon College

Policy Related to Pregnancy

Any student who is pregnant while enrolled in nursing classes must provide documentation that they are medically clear to attend and participate in clinical experiences during the last month of the pregnancy, for any complicated pregnancies, and post partum. See Division office for appropriate form

I have read and understand this policy.

Signed____________________________________________________________________

Office Address____________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Telephone Number:____________________________________________________________________

Date____________________________________________________________________________

I, ____________________________________________, authorize Gordon College Nursing Program to request and receive information related to my medical history from the listed physician or Nurse Midwife’s office.

Printed Name__________________________________________

Signed: ___________________________________________

Social Security Number__________________________________