

## School of Health Professions & Education Medical Information Receipt (MIR)

Student Name	SID
MMR/Meningitis Form completed Date	Reviewed by:
SHP Clinical form completed Date	
Please indicate the following from the student's form –	
May participate in clinical experience in health care age	encies or organizations
Must be restricted or adaptive program designed for /based on her/his limitations. Indicate specific limits	
Should not participate in clinical experiences	
Approved/Reviewed by:	STAMP
SHP Clinical form completed Date	
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Approved / Povioused by:	CTANAD