Student's Name: _____
UH ID#: _____
Program:_____

UNIVERSITY OF HAWAI'I • KAPI'OLANI COMMUNITY COLLEGE

Nursing Department

DOCUMENT RELEASE FORM

I hereby authorize release of my immunization, photograph, titer records, CPR, TB, health and malpractice insurance records for review by the faculty & nursing advisors of the Kapiʻolani Community College Nursing Department. I understand that these records and photograph will be copied to provide evidence of my immunizations, CPR, TB and insurance status for the agencies in which I will likely have clinical experiences.

Print Name _____

Signature _____

Date _____