Mineral County School of Practical Nursing

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Primary Care Provider Clearance: Controlled & Mood-Altering Substances

Student ______________________________ Date ______________

SS# ______________ DOB ______________ Age __________

Primary Care Provider Name ______________________________

Primary Care Provider Address ______________________________

Primary Care Provider Phone # ______________________________

Medication (Include Dose, Route, Frequency)	Purpose

Date of Physical Examination ______________________________

Summary of Findings ______________________________

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I have reviewed all of the student's medications as listed above. I have examined her/him. Based on the findings of my assessment and my professional judgment, I believe the above student is able to perform nursing functions safely and, therefore, provide direct patient care. I am released from any liability by making this statement.

______________________________ ______________

Primary Care Provider Signature Date

Written 12/04
Reviewed 12/06; 12/08; 12/10; 12/12; 12/14

Reference: MCSPN "Drug Testing Policy"