Medical Release Form

Instructions to the treating physician: *Please complete, sign and return by mail or fax (818) 841-8006 to the Kids' Community Dental Clinic. Thank you.*

I have examined _____ on this date

_____. The individual noted has no existing health conditions that would create a hazard for himself, other employees, patients or visitors of the Kids' Community Dental Clinic and is fully able to perform assigned duties of the dental clinic with patients who are at a high risk for poor health, recent immigrants and others in the public health arena.

☐ Attached are the results of a current TB skin test.

_____ _____

Signature of Physician Date

Please print clearly or stamp

Doctor Name & Address

_____

_____

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