



Cal Poly Maritime Academy
Readmission Health Statement

Please return this form to the Student Health Center

Student Name _____
Date of Birth _____
Phone Number _____
Address _____

ID # _____
Last Term Attended _____
Major _____ License track Y / N
Left school for medical reasons Y / N

Student seeking readmission to Cal Poly Maritime after absence of a calendar year or less may submit this form to request health clearance prior to readmission. Most students will need only this form or to submit minimal additional health information to be cleared. If absent for more than one calendar year student must submit a completed new student Admission Health Packet.

Unreported changes in a student's health status may limit participation in some campus programs or limit the ability to be licensed by the US Coast Guard (as applicable to specific majors).

Please check off the statements that apply to your situation:

- I certify that to the best of my knowledge, my health and physical condition has not changed during the period of my absence from the Cal Poly Maritime Academy, that I am in good health.
- I have had changes to my health during my period of absence from the campus or since being admitted to Cal Poly Maritime Academy.
(Please contact the Student Health Center regarding submitting additional information)
- I am seeking readmission to Cal Poly Maritime after leaving school for health reasons or taking a medical withdrawal.
(Please contact the Student Health Center regarding submitting additional information).
- I have traveled internationally during my absence from Cal Poly Maritime.
(Tuberculosis screening may be required for extended travel to certain areas, please contact the Student Health Center).

I attest that all of the above information is accurate.

Student Signature

Date

Student Health Center
Cal Poly Maritime Academy
200 Maritime Academy
Drive Vallejo, CA 94590
Phone: 707-654-1170
Fax: 707-654-1171

For office use only:

Reviewed: Y / N Reviewer's initials: _____ Cleared for readmission: Y / N Provider Initials: _____

Additional Information needed: _____