THE LEADER IN GLOBAL EDUCATION

FAIRLEIGH DICKINSON UNIVERSITY

Medical Consent Form

I, _____, hereby give my written permission to have the Fairleigh Dickinson University Florham Campus Dean of Students Office to release all pertinent medical, social, psychological or psychiatric information which pertains to my case.

_____

Name of individual and /or organization

_____

Address

I furthermore release all parties stated here within from any liability resulting from the release of this information, with the understanding that all parties involved will exercise sufficient safeguards while using this information.

_____

Signature of patient/client **Date**

FOR PHYSICIAN'S USE ONLY
Please indicate the diagnosis, manifestation and/or functional limitations of the condition, and foods that a student can and cannot eat.

PATIENT IS ABLE TO EAT	PATIENT IS UNABLE TO EAT

Please provide additional information or comments below (Attach additional information, as necessary)

_____

_____

_____

_____

_____

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IS TRUE REGARDING THE ABOVE NAMED PATIENT;

_____

Physician's Name (please print) Address

_____

City State Zip E-Mail

_____

Physicians Signature Date

Note: Please return this form to the patient directly for completion of the request process.