



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. | |
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| PATIENT IS ABLE TO EAT | PATIENT IS UNABLE TO EAT |
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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.