MEDICAL RELEASE REQUEST

NAME (PRINT): ____

MUID - ______________________________ DATE OF BIRTH: ______________________________

BUILDING AND ROOM #:_____________________________________CELL PHONE: _______________

NAME OF ( ) PARENT/ ( ) LEGAL GUARDIAN: ____

HOME ADDRESS: ____
STREET/BOX NUMBER CITY STATE ZIP

HOME TELEPHONE NUMBER: _____________________________________

I WISH TO BE RELEASED FOR [ ] FALL SEMESTER 20_____ [ ] SPRING SEMESTER 20_____

DOCUMENTATION REQUIRED TO ACCOMPANY THIS FORM:

( ) Statement from an attending physician with description of medical condition and reasons for release request **on appropriate letterhead**.

Appropriate documentation is **required**, and release request will not be considered without it
All supporting materials must be attached and submitted with this form. Student signature (or parent/guardian signature for students under age 18) is required on this document.

The information supplied on this request is, to the best of my knowledge, accurate. If false information is submitted, I understand that my release will automatically be denied and I may be referred for disciplinary action.

SIGNED: ____DATE:____________________