Institut d'Avignon

Physician's Statement

Summer 2016

TO THE APPLICANT: Please authorize by your signature below the release of any medical information that may be relevant in the opinion of your physician to your participation in a study abroad program.

YOUR NAME: _____

YOUR SIGNATURE: _____ DATE: _____

TO THE PHYSICIAN: Please indicate if the student named above has a history of chronic or disabling physical conditions; any allergies which may require either continuing or emergency treatment; any special dietary problem; or any other physical or emotional condition which might effect his/her well-being or that of fellow students while living or travelling outside the United States for an extended time. Please, list the generic names for any prescription medicine the student requires which may not be readily obtainable abroad.

Physician's Name: _____ Signature: _____

Address: _____ Date: _____

_____

_____

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Please return this form by May 2, 2016