RESIDENCY REQUIREMENT MEDICAL RELEASE
HOUSING AND RESIDENCE LIFE

NAME: _____

ID#: _____

DATE OF BIRTH: _____

REASON FOR MEDICAL RELEASE: _____

_____

_____

NAME OF PHYSICIAN: _____

PHONE NUMBER: _____

ADDRESS: _____

_____

I hereby authorize the above captioned physician to release my medical history and condition to determine if off campus housing is warranted to:

Bethune-Cookman University
Assistant Vice President of Health Services
Housing and Residence Life
640 Mary McLeod Bethune Blvd., Daytona Beach, FL 32114
(386) 481-2420

NAME: _____ ***DATE:*** _____
(Please Print)

SIGNATURE: _____