

To be completed and signed by student's physician.

1. Does the student have allergies to medications? If so, specify.

2. Does the student have other allergies? Please specify.

3. Is the student currently taking prescription medicine? If so, specify.

This statement is to verify that _____ is in good health and is able to participate in the activities of the study abroad program.
(name of student)

Physician's Name _____

Signature _____ **Date** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Phone _____

Clinic, Hospital, or Physician's Office
Address Stamp

Please return this statement to:
Center for International Services and Programs
Cleveland State University, Keith Building, Suite 1150, 2121 Euclid Avenue, Cleveland, OH 44115.
Phone: (216) 687-3910, Fax: (216) 687-3965.