Medical Emergency Form
Department of Economics at the University of Michigan
April 10, 2013

This form should be used (only) when the student believes the student's medical condition would significantly impair the student's ability to perform normally on a midterm or final examination.

To my physician, physician’s assistant, or nurse:
I am concerned that my present medical condition might significantly impair my ability to perform normally on a midterm or final examination. I am aware that the HIPAA Privacy Rule prevents you from releasing my medical information to third parties without my consent. I hereby request that you complete the following form and give it to me, together with the completed UHS Visit/Verification Medical Statement.

To be completed in advance by the student:
Student’s full name (printed) __________________________________________
Student’s signature __________________________________________
Student’s UMID ______________________________
Course examination date __________________________________________
Medical examination date __________________________________________

To be completed by the physician (or, at UMHS, by the PA or nurse); please print:
Please answer the following four questions, placing an “X” in each appropriate O:

   Question 1. Did you tell this student to "stay at home" between now and the course examination?
   O Yes        O No

   Question 2. If you answered “yes” to question 1, until when did you tell this student to “stay at home?”
   Month: ___________  Day: _____

   Question 3. Does the student have an acute medical condition (e.g., a concussion) that is likely to impair significantly the student’s ability to perform normally on a course examination on the date specified above?
   O Yes        O No

   Question 4. Would this student put others at health risk if the student were to attend a course examination on the date specified above?
   O Yes        O No

Printed name of physician, PA, or nurse __________________________________________
Signature of physician, PA, or nurse __________________________________________
Title of physician, PA, or nurse __________________________________________

Official stamp of the health care organization: