



# The Pfeiffer Center

BIODYNAMICS AND ENVIRONMENTAL STUDIES

## Medical Form

Please complete this form, have it signed by your physician and return it to:  
The Pfeiffer Center, 260 Hungry Hollow Rd, Chestnut Ridge, NY 10977

**Please print or type:**

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Name (Last, First, Middle Initial)

Date of Birth

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Address

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Home Phone

Work Phone

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E-mail Address

Sex: M  F  Marital Status (optional) \_\_\_\_\_

Name and address of your physician:

Please state the reason for any significant hospitalization you have undergone:

Please list any major illnesses you have had:

Is there anything you feel we should be aware of concerning your health?

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I have examined the above-named person. He or she is physically and emotionally healthy and should be able to pursue a course of college studies.*

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_