



Medical Release/Activity Permission Form

Pertaining to the involvement in any sanctioned activity of the Admissions Office at Arizona Christian University.

Student Information

Name _____ Age _____
 Address _____ Apt _____
 City _____ State _____ Zip _____
 Name of Health Insurance _____
 Insurance Group # _____ I.D. # _____
 Specialist _____ Health Insurance Phone _____
 Student allergies, chronic illness, or other medical conditions (if any): _____

Current Medications

<u>Name of Medicine</u>	<u>Dosage/Frequency</u>	<u>Termination Date</u>

____ Student may be given Tylenol ____ Student may **NOT** be given Tylenol
 ____ Student may be given _____ (Specified Pain Reliever)

Emergency Contact Information

Name _____ Relationship _____ Home Phone () _____
 Work Phone () _____ Pager/Mobile Phone () _____

Alternate Emergency Contact(s)

<u>Name</u>	<u>Relationship</u>	<u>Phone Number</u>

Student Signature _____ **Date** _____

Parent/Guardian Information (If student is under the age of 18 at the time of the event)

To be filled out by an adult authorized to give consent for the above named student to participate in *Experience* activities at Arizona Christian University, as well as being authorized to give permission for the above named student to receive medical attention.

I, _____ (please print), as the mother, father, legal guardian (circle one), of the above named student, do hereby consent to his/her involvement in the sanctioned activities of *Experience* at Arizona Christian University. Furthermore, in the event that my child sustains any condition requiring medical attention (including, but not limited to diagnostic procedures, surgical treatment, blood transfusions, and dental care) during or as a result of the Experience event, I consent to the rendering of such treatment by authorized members of the hospital staff or their designees as may in their professional judgment be necessary. I also give my consent to an authorized representative of Arizona Christian University to arrange for any care and treatment necessary to preserve the health of my child.

I understand the contents of this form and agree to all parts that I have not crossed out and initialed. I hereby acknowledge that no guarantees have been made to me as the effect of such examinations or treatment on my child's condition.

I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered during this period and release Arizona Christian University of any liability.

Parent/Guardian Signature _____ **Date** _____