Biola Youth Academics Medical-Media Release

One form per student with a minimum of one parent signature required.
Print, sign and send to BYA Registration, 13800 Biola Avenue, La Mirada, CA 90639
OR scan and email to youth.registration@biola.edu

In the rare instance of a medical emergency at a Biola Youth Academics sponsored activity in which the parents cannot be reached, we will need the following information, including the signed release below, which covers the student enrolled in a Biola Youth Academics program of Biola University.

Student's full name _____ Gender: male female

Date of birth ____/____/____ Date of last tetanus shot ____/____/____

Insurance provider _____ Account # _____

Physician _____ _____
Name Phone number

Physician's address _____

Is student taking any medication? No Yes Specify _____
Name of medication

Allergic to _____

Health conditions _____

Restricted activities or foods _____

I (we), the undersigned parent, parents or legal guardian of the student named above, a minor, do hereby request that he/she be permitted to participate in any Biola Youth Academics activity; should the need arise, I do hereby authorize and consent to any X-ray examination, anesthetic, and medical or surgical diagnosis rendered under the general or special supervision of any member of the medical and emergency room staff licensed under the provisions of the Medicine Practice Act, Dentist licensed under the provisions of the Dental Practice Act, and the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care that the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatments will not be withheld if the undersigned cannot be reached. I will not hold liable Biola University, its officers, or employees for medical aid rendered and will reimburse the University for medical or other expenses incurred in the care of my student. This authorization is given pursuant to Section 25.8 of the Civil Code of California and remains effective only for the student listed at the top of this document. Biola University does not pay physician fees or medical expenses of students who are injured at Biola Youth Academics classes or at Biola Youth Academics sponsored activities.

I (we) understand that by participating in Biola Youth Academics, I give permission for the publication of photographs, videos, and recordings taken during participation in any Biola Youth Academics activity, to be used in promotional materials. I understand that I will not be paid any royalty or other compensation; and I give up any right I may have to payment if photos, videos, or recordings are published. I agree that any such photo, video, or recording shall become the sole property of Biola University, Inc.

Father/Legal Guardian Primary phone (____) _____

Name _____ Work phone (____) _____
Print

Signature _____ Date _____
Original signature required

Mother/Legal Guardian Primary phone (____) _____

Name _____ Work phone (____) _____
Print

Signature _____ Date _____
Original signature required

Local Emergency Contacts (Other than parents)

Name _____ Relationship _____

Primary phone (____) _____ Secondary phone (____) _____

Name _____ Relationship _____

Primary phone (____) _____ Secondary phone (____) _____