



# IGNITE Teams 2019- Student Medical Release

Complete **both sides of this form** and bring to event (one form per student)

**Medical Release:** In the rare instance of a medical emergency at a Biola Youth 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 the Biola Youth program of Biola University.

Student Name \_\_\_\_\_ Insurance Provider: \_\_\_\_\_

Account # \_\_\_\_\_ Physician: (Name) \_\_\_\_\_

(City) \_\_\_\_\_ Physician Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Is student taking any medication? Y N

If yes, specify Name of Medication \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_/\_\_\_\_/\_\_\_\_ Health Conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Restriction activities / foods: \_\_\_\_\_

Local Emergency Contact: (Not Parent) \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Local Emergency Contact: (Not Parent) \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I (we), the undersigned parent, parents or legal guardian of the student above named, a minor, do hereby request that he / she be permitted to attend any field trips, excursions or classes given by Biola University's Biola Youth programs; 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, Southern California Youth For Christ and other participating organizations, their officers, or employees or 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. The university does not pay physician fees or medical expenses of students who are injured at Biola Youth sponsored activities.

I (we) understand that by participating in Biola Youth programs, I give permission for the publication of photographs, videos, and recordings taken during participation in Biola Youth classes and events, 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. and Southern California Youth. For Christ.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (\_\_\_\_) (\_\_\_\_)  
Parent or Legal Guardians Signature Date Printed Name Home Phone Cell Phone

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (\_\_\_\_) (\_\_\_\_)  
Parent or Legal Guardians Signature Date Printed Name Home Phone Cell Phone