

# CAMPUS GUEST MEDICAL RELEASE FORM

My child has no physical conditions which will keep him/her from participating in the full range of activities being planned. I authorize Bob Jones University to act for me according to its best judgment in any emergency requiring medical attention. If medical attention is advised by Bob Jones University but upon parental notification that treatment is refused, I understand that my child will not be permitted to remain. I also understand that the University is not responsible for any expense incurred because of any injury or illness.

Visitor's name \_\_\_\_\_  
LAST FIRST MIDDLE NAME HE/SHE GOES BY

Date of birth \_\_\_\_\_  Male  Female

Date of visit \_\_\_\_\_

Name of responsible party \_\_\_\_\_

Insurance provider \_\_\_\_\_

Insurance company phone ( \_\_\_\_\_ ) \_\_\_\_\_

Policy number \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

Phone number of responsible party ( \_\_\_\_\_ ) \_\_\_\_\_

E-mail of responsible party \_\_\_\_\_

Please list any medical conditions of which we should be aware: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please bring this form with you to check-in.**