

MEDICAL/INFORMATION RELEASE FORM

**GENERAL EMERGENCY CONSENT AND RELEASE FORM FOR MINORS TO
THE ORGANIZATIONS NAMED BELOW UNDER THE CARE OF
DR. DANIEL BORKERT, DR. KURT HARDING, DR. JEAN SAITO and DR. TONYA WREN
BOB JONES UNIVERSITY PUBLIC SAFETY DEPARTMENT
GREENVILLE COUNTY EMS
UNIVERSITY MEDICAL ASSOCIATES, P.A.**

I hereby agree and give my consent for emergency and/or supportive treatment to:

Name _____
(Last) (First) (Middle) (Birthdate)

as deemed necessary by the personnel of the Bob Jones University Public Safety Department and the W. J. Barge Memorial Hospital.

HEALTH AND MEDICAL PROBLEMS (professionally diagnosed)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Bronchitis, chronic | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Vision loss |
| <input type="checkbox"/> Congenital defect | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes, controlled | <input type="checkbox"/> Thyroid, overactive | <input type="checkbox"/> Bleeding trait | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Diabetes, uncontrolled | <input type="checkbox"/> Thyroid, underactive | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Sinus trouble, chronic |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Serious injury, permanent damage (describe) _____ | | |
| <input type="checkbox"/> Communicable disease (identify) _____ | | | |

ALLERGIES (skin rash, hives, joint pain, swelling, or fever as a reaction to)

- | | | | | |
|--|---|---|--------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Molds, fungi | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Milk | |
| <input type="checkbox"/> Bee stings | <input type="checkbox"/> Pollens, ragweed | <input type="checkbox"/> Tetanus toxoid | <input type="checkbox"/> Peanut Oil | |
| <input type="checkbox"/> Certain animals | <input type="checkbox"/> X-ray media | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Eggs | | | | <input type="checkbox"/> Medications (list) _____ |

If any condition above is checked, please give directions for taking care of your child on the reverse side of this form.

Is your child covered by Bob Jones University insurance policy? ___ If not, please fill out insurance information below.

Health Insurance Policy No.: _____

Named Insured: _____

As Parent or Legal Guardian, I understand that Bob Jones University is not responsible for any expense incurred because of an injury or illness.

(NAME) (please print)

(SIGNATURE)

I give the CDC staff permission to administer
 Tylenol
 Benadryl
to my child, as needed, according to the recommended dosage.

(SIGNATURE)

(Date)