

EMERGENCY MEDICAL RELEASE FORM

I _____, give permission to my son /
Please Print Full Name

Daughter _____, to visit the Franciscan
Please Print Full Name

University on the _____ . If needed for health
Print Dates of Visit

reasons, I give permission for my child to be evaluated, diagnosed, treated, and/or given medication in accordance with the standard medical practice by licensed medical personnel. I relieve Franciscan University of Steubenville of all responsibility and consequences that may arise as a result of this treatment. I will not hold Franciscan University of Steubenville liable in the event of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling medical treatment.

My son / daughter agrees to abide by all rules and regulations stated by Franciscan University of Steubenville Staff including Admissions and Resident Staff. I understand that while visiting the campus my son / daughter is unchaperoned during their visit, in like manner as any University student. I understand that Franciscan University of Steubenville will not be liable if my child fails to cooperate with regulations, and that any infraction of the rules may result in immediate termination of their visit and all expenses in returning them home will be at my expense.

Parents Signature

Guest Signature

FAMILY PHYSICIAN _____ PHONE # _____

Allergies: _____

Current Medications: _____

Medical History: _____

Guest Participant's Social Security Number ____ - ____ - _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Name: _____

Address: _____ Address: _____

Home PH# _____ Home PH# _____

Work PH# _____ Work PH# _____