

# Release Liability & Medical Release Form

## Emergency Contact & Medical Information

FIRST NAME: \_\_\_\_\_

LAST NAME: \_\_\_\_\_

SEX: \_\_\_\_\_

DOB: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Parent/Guardian: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Other Emergency Contact Person: \_\_\_\_\_

Relation to Student: \_\_\_\_\_

Message Phone: \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Please list any medical conditions:

Please list current medication/s:

Please list allergies (food, medication, etc.):

### RELEASE LIABILITY

I wish (for my student) to participate in the EOP Summer Bridge Orientation Program from August 16-20, 2014. I realize that the event may be strenuous and there may be adverse weather conditions. Nevertheless, I wish (for my student) to participate and assume the risks involved. I certify that I (my student) am/is in good health and that I (my student) am/is able to participate in this orientation program. I assume and agree to hold harmless the Educational Opportunity Program and Humboldt State University.

### MEDICAL RELEASE

I/We, the undersigned/the parent (s) of \_\_\_\_\_,  
undersigned / minor

do here authorize the Summer Bridge Orientation Program as agent(s) for the undersigned to consent to any X-ray examinations, anesthesia medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, and physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office or said physician or at said hospital. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. I/We hereby authorize any hospital that has provided treatment to the above named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to my/our above named agent(s) upon the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

Please bill the Summer Bridge Orientation Program for ACCIDENTS ONLY. For illness not related to an accident, please bill the parent/guardian. I fully understand the scope of this activity and I voluntarily sign this form.

Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian (if under 18): \_\_\_\_\_

Date: \_\_\_\_\_

**IMMEDIATE RESPONSE REQUIRED** - Please return this form along with your EOP Contract.

Mail to: Humboldt State University - EOP Admissions Office - 1 Harpst St., HH #56 - Arcata, CA 95521 \* Fax to: 707.826.4180