

Chronic or recurring illness or medical condition: _____

Dietary restrictions: _____

Current Medications: _____

Special health and behavioral considerations: _____

V. RELEASE OF LIABILITY AND AUTHORIZATION FOR TREATMENT:

I acknowledge that by signing this document, I am agreeing to release William Jessup University, including its members, trustee, employees and agents (herein referred to as releasees) from all liability. I have therefore been advised to read this document carefully before signing it.

The undersigned hereby acknowledges that: he/she is of legal age to execute this Release of Liability form on his/her own behalf -OR- I am the parent or legal guardian of the above named individual AND I hereby release, hold harmless, waive, discharge and covenant not to sue or bring any action whatsoever against the above releasees from all liability to the releasers for all loss or damage and any claim or demands on account of injury to the person or property or resulting death of the releasers, whether caused by negligence of releasees or otherwise while participating in the above-named activity associated with William Jessup University.

The undersigned hereby consents to any x-ray, examination, anesthetic, medical, surgical or dental diagnosis, or treatment and hospital care or service, which is deemed advisable and is rendered under the general or specific supervision of any licensed physician and surgeon, or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. I understand that all efforts will be made to contact a parent or legal guardian prior to treatment. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being rendered, but is given to provide authority and power on the part of William Jessup University in the event of my disability to give specific consent to any and all such diagnosis, treatment or hospital care which the above mentioned physician, in the exercise of his/her best judgment, may deem advisable.

Further, I understand that I am responsible for the health care decisions made and agree that my insurance plan is the primary plan to pay for dental, medical or hospital care or treatment rendered.

Note: The undersigned student is responsible to contact WJU for any contact changes/updates.

Signature _____ Date _____