CONSENT FORM

NAME OF MINOR (PLEASE PRINT)_______________________________________ DATE:_______________

I HERBY GRANT MY PERMISSION FOR THIS MINOR TO STAY OVERNIGHT AT RANDALL UNIVERSITY. I UNDERSTAND AND WILL NOT HOLD RANDALL UNIVERSITY RESPONSIBLE FOR ANY INCIDENT THAT MAY OCCUR WHILE THE MINOR IS ON CAMPUS. I AGREE THAT THE MINOR WILL BE HELD RESPONSIBLE FOR ANY DAMAGES THAT OCCUR WHILE ON CAMPUS AND I ASSUME ANY OF THE EXPENSES THAT MAY INCUR DUE TO SUCH AN INCIDENT.

SIGNATURE____ PRINTED NAME____

RELATIONSHIP TO MINOR______________________________________

EMERGENCY INFORMATION

NAME____ DATE__________________________________

PARENT/GUARDIAN NAME____ PHONE________________________________

HOME ADDRESS____

INSURANCE COMPANY____ POLICY #_____________________________

INSURANCE PHONE FOR AUTHORIZATIONS____

EMERGENCY CONTACT PERSON____ PHONE________________________________

EMERGENCY CONTACT PERSON____ PHONE________________________________

ALLERGIES____

MEDICATIONS____

DOCTOR____ PHONE________________________________

I HERBY GRANT MY PERMISSION TO AND AUTHORIZE AN OFFICIAL OF RANDALL UNIVERSITY TO SIGN ANY FORMS NECESSARY IN ORDER THAT I MAY RECEIVE EMERGENCY MEDICAL TREATMENT. I UNDERSTAND THAT WHEN THE OFFICIAL OF THE COLLEGE SIGNS THE PROPER FORMS, PERMISSIONS IS BEING GRANTED AND AUTHORIZATION FOR THE CONSULTED DOCTOR AND/OR DOCTORS ON THE STAFF OF A HOSPITAL OR CLINIC TO GIVE SUCH TREATMENT OR SERIES OF TREATMENT, ORDER SUCH MEDICATIONS, ANESTHETICS AND PERFORM SUCH OPERATIONS AS IN THEIR OPINION ARE FOUND NECESSARY OR IS NECESSARY TO PERFORM THE SERVICES REQUESTED BY A PRIVATE PHYSICIAN WITH A DISTINCT UNDERSTANDING THAT THERE MIGHT ARISE SOME DANGER IN SAID TREATMENT OR OPERATION, AND I LEAVE THE WHOLE MATTER OF PROCEDURE AND TREATMENT TO THE BEST JUDGEMENT OF SAID DOCTORS. I AGREE TO ASSUME RESPONSIBILITY FOR ALL EXPENSES INCURRED.

SIGNATURE____ PRINTED NAME____

RELATIONSHIP TO MINOR______________________________________