

Medical Authorization and Release Form

(Over 18 years of age)

I, (print name) _____
the undersigned, of (address): _____
City of _____, County of _____, State of _____,
hereby agree as follows;

In the event of any accident, sudden illness, or medical emergency involving myself in connection with the below mentioned trip, I hereby authorize the following staff members of Campus Crusade for Christ, Inc. (names to be filled in by staff members): _____

to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, deemed to be necessary by a licensed physician. This authorization is limited to the following dates: _____, 20____, through and including _____, 20____.

The following information is included and may be resorted to if needed by any hospital or licensed medical practitioner not having access to my medical history:

Allergies: _____

Medical conditions: _____

Physical impairments: _____

Medication being taken: _____

Other pertinent facts: _____

In consideration of being permitted to participate in the Campus Crusade for Christ trip to (location): _____
beginning on (date) _____, 20____, and ending on _____, 20____, I, the undersigned, ("Releasor"), hereby release, waive, discharge, covenant not to sue, agree to indemnify and hold harmless, Campus Crusade for Christ, Inc. and their officers, directors, agents, affiliates, employees and assigns ("Releasees") from any and all damages, liability, causes of action or any other form of liability, past, present or future, and whether caused by the negligence of Releasees or otherwise, arising out of or relating to my presence or participation in the aforementioned Campus Crusade for Christ trip and any activities related thereto, or any actions taken by Releasees pursuant to the above medical authorization with the respect to myself.

This release shall be binding on myself, my heirs, executors and legal representatives.

EXECUTED THIS _____ DAY OF _____, 20____.

SIGNATURE _____

Medical Insurance Confirmation

Please check the appropriate box:

Yes, I am personally covered by the following medical insurance plan:

Medical No./Insurance Company and Policy Number: _____

This policy will be in effect while I participate in the Campus Crusade for Christ sponsored event to held at: (location) _____

beginning on _____, 20____ and ending on _____, 20____.

No, I am not personally covered by any medical insurance plan.

Signature _____ Date _____

If minor: Signature of Parent or Guardian _____

Date _____