



WILLIAM JESSUP UNIVERSITY OVERNIGHT VISITOR EMERGENCY CONTACT AND LIABILITY RELEASE FORM

WILLIAM JESSUP
UNIVERSITY

I. GUEST INFORMATION:

Name _____ Sex ____ Age _____ Cell(_____) _____-_____
Home Address _____
Street City State Zip

II. NAME OF PARENTS OR LEGAL GUARDIAN (EMERGENCY CONTACT INFO):

Name: _____
Home Address _____
Street City State Zip

Phone: Home (_____) _____-_____
Work (_____) _____-_____
Cell(_____) _____-_____

Name: _____
Home Address _____
Street City State Zip

Phone: Home (_____) _____-_____
Work (_____) _____-_____
Cell(_____) _____-_____

III. MEDICAL INFORMATION AND HISTORY:

Physician _____ Phone (_____) _____

Medical Insurance Provider Name _____ Policy No _____

DRUG ALLERGIES:

HEALTH HISTORY:

Operations or serious injuries (dates): _____

Chronic or recurring illness or medical condition: _____

Dietary restrictions: _____

Current Medications: _____

Special health and behavioral considerations: _____

IV. AUTHORIZATION FOR TREATMENT

I acknowledge that by signing this document, I am agreeing to release William Jessup University, including its members, trustees, 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 as an overnight guest of a William Jessup University on-campus resident.

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 the dental, medical, or hospital care or treatment rendered.

Visitor Signature _____ Date _____

V. WJU RESIDENT INFORMATION:

Name _____ Dorm _____ Wing/Room # _____

Phone: Home (____) ____-____ Work (____) ____-____ Cell(____) ____-____

I understand that guests are subject to all residence life rules and that I am responsible for their adherence to these rules and could be held responsible for their actions. Additionally, I am aware that I am financially responsible for the actions and conduct of my guest(s), and understand that any items issued to my guest(s) during their stay and not returned to the proper WJU authority will be charged to my student account. Items issued to guests may include, but are not limited to: residence hall keys, access badges, and parking permits.

Resident Signature _____ Date _____

FOR OFFICE USE ONLY:

Dorm/ Room Assignment: _____ Dates of Stay: _____

Visitor Card# _____ Access Given: _____

Temporary Parking Permit # _____ Returned: Keys Access Card Permit Init. _____

RD approval _____ Date: _____