Medical Release and Consent Authorization

Activity: _____ Start Date: _____ End Date: _____

Participant Name: _____ Birth date: _____

Participant:

Address: _____

Phone: _____

Emergency Contact:

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Medical Information:

Insurance Provider: _____ Policy Holder Name: _____

Policy ID Number: _____ Group ID Number: _____

Insurance Provider Phone: _____ Insurance Provider Fax: _____

Physician Name: _____ Physician Phone: _____

Physician Address: _____

Known Medical Issues and Medications:
(This information is used only in the event it needs to be provided to emergency personnel in an emergency situation. Concordia accepts no responsibility to distribute medications or ensure any prescribed medication is properly taken by the participant.)

Medical Issue: _____ Medication Taken: _____

Dosage Taken: _____ Dosage Frequency: _____

Medical Issue: _____ Medication Taken: _____

Dosage Taken: _____ Dosage Frequency: _____

Medical Issue: _____ Medication Taken: _____

Dosage Taken: _____ Dosage Frequency: _____

Allergies: _____

_____

Medical Release and Consent Authorization

Activity: _____ Start Date: _____ End Date: _____

Participant Name: _____ Birth date: _____

CONSENT

I GRANT CONCORDIA UNIVERSITY TEXAS, AND ANY RELATED AND AFFILIATED ENTITIES (CONCORDIA) FULL AUTHORITY TO TAKE WHATEVER ACTION THEY FEEL IS WARRANTED UNDER THE CIRCUMSTANCES REGARDING MY PHYSICAL AND MENTAL HEALTH AND SAFETY, INCLUDING PLACING ME, AT MY OWN EXPENSE, IN A HOSPITAL AT ANY POINT FOR MEDICAL SERVICES AND TREATMENT, OR IF NO HOSPITAL IS AVAILABLE, TO PLACE ME IN THE HANDS OF A LOCAL HEALTH CARE PROVIDER FOR TREATMENT. CONCORDIA IS FURTHER AUTHORIZED TO RETURN ME TO MY PLACE OF ORIGINAL DEPARTURE OR TO ANOTHER LOCATION FOR MEDICAL TREATMENT IF NECESSARY. IN THE EVENT THAT I AM UNABLE TO ACT FOR MYSELF, I HEREBY AUTHORIZE CONCORDIA'S EMPLOYEE(S) OR AGENT(S) WHO IS SUPERVISING THE PROGRAM TO ACT ON MY BEHALF IN AUTHORIZING AND CONSENTING TO EMERGENCY MEDICAL CARE INCLUDING SURGERY, IF NECESSARY, DENTAL CARE, AND/OR HOSPITALIZATION IF I BECOME ILL OR AM INJURED WHILE PARTICIPATING IN THE PROGRAM. THIS AGREEMENT MAY BE PRESENTED TO THE APPROPRIATE MEDICAL/DENTAL STAFF AT SUCH TIME AS EMERGENCY MEDICAL CARE, DENTAL CARE OR HOSPITALIZATION IS REQUIRED.

RELEASE

ULTIMATELY, I ASSUME ALL RISK FOR THE COST OF MY MEDICAL CARE, INCLUDING TRANSPORTATION AND HOSPITALIZATION, WHILE IN, OR IN TRANSIT TO OR FROM, ANY DESTINATION. I HEREBY FOREVER RELEASE AND DISCHARGE CONCORDIA UNIVERSITY TEXAS, ALL RELATED, AFFILIATED, PARENT AND SUBSIDIARY ENTITIES, INCLUDING BUT NOT LIMITED TO THE LUTHERAN CHURCH—MISSOURI SYNOD (LCMS), THE TEXAS DISTRICT OF THE LCMS, THE CONCORDIA UNIVERSITY SYSTEM AND EACH ENTITIES' PAST AND PRESENT BOARD MEMBERS, OFFICERS, DIRECTORS, EMPLOYEES, AGENTS, AND INSURERS FROM ANY AND ALL CLAIMS OF ANY NATURE WHATSOEVER WHICH MAY ARISE OUT OF THE DECISION TO PROVIDE EMERGENCY MEDICAL CARE, DENTAL CARE OR HOSPITALIZATION DURING THE ACTIVITY.

I have read this release and consent authorization and understand the terms used in it and their legal significance. This release and consent authorization is freely and voluntarily given.

Participant Signature: _____ Date: _____

Parent / Guardian (*Required if Participant is a Minor*) - I certify that I am the parent/legal guardian of the above named participant and I consent to medical treatment for my child. I have reviewed this completed form and certify the information is correct and I HAVE READ THE RELEASE AND CONSENT AUTHORIZATION AND UNDERSTAND ITS CONTENTS.

Name: _____ Signature: _____ Date: _____

Notary of the Public (*Required if Participant is a Minor*)

State of Texas
County of _____

_____, personally appeared before me on _____, and signed this Medical Release and Consent Authorization, and further states that he/she has read the above Medical Release and Consent Authorization and the statements therein contained are true.

Notary Public's Name: _____

Notary Public's Signature: _____

Commission Expires: _____

(Personalized Seal)