ASBURY UNIVERSITY
Academic Excellence & Spiritual Vitality

Medical Release for Minors
Health Services

Minor's Full Legal Name: **Date of Birth:**

Street Address:

City/State/Zip:

I, the undersigned parent of the above-named minor, know that I may not be available to authorize medical care of said minor child, and in the event where I cannot be contacted wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give **Asbury University Health Services** the right to give consent to authorize medical care. Whereas "Asbury University Health Services" pertains to any Registered Nurse(s)/Physician(s) hired by or in contract with Asbury University.

It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that this authorization relieve the physician, dentist, or other person rendering such care at the hospital or institution in which such care is given, from any liability resulting from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that Asbury University Health Services shall act in my stead in making such decisions.

_____ _____
Signature of Parent/Guardian **Date**

_____
Printed Name of Parent/Guardian

If the injury or illness is life threatening or in need of emergency treatment, I authorize Asbury University Health Services to summon any and all professional emergency personnel to attend transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.
It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power to Asbury University Health Services in the exercise of their best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through _____.
Date

_____ _____
Signature of Parent/Guardian **Date**

_____
Printed Name of Parent/Guardian

NOTARY FORM

(A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document, to which this certificate is attached, and not the truthfulness, accuracy, or validity of that attachment.)

Notary seal here

STATE OF_____ COUNTY OF_____

The foregoing instrument was acknowledged before me this ____day of

_____, 20____ by _____ personally known to

me or who has produced _____ as identification.

_____ _____
Name of Notary (Printed) Commission Expiration Date