Student Liability Release For Those 18 and Over

In consideration of being permitted to participate in Fall Orientation 2015 on Friday, August 21 - Saturday, August 29, 2015 and Saturday, September 5, 2015, I, the undersigned, in full recognition and appreciation of the dangers and hazards inherent in this activity including transportation to and from such activity, do hereby agree to assume all the risks and responsibilities surrounding my participation in the activity: and, further, I do for myself, my heirs, and personal representative(s) hereby defend, hold harmless, indemnify, and release, and forever discharge BIOLA UNIVERSITY, INC., and all its trustees, officers, representatives, agents, and employees from and against any and all claims, demands, actions, or causes of action, on account of damage to personal property, or personal injury, or death which may result from my participation in the activity, and which result from causes beyond the control of, and without the fault or negligence of BIOLA UNIVERSITY, INC., its trustees, officers, representatives, agents, or employees.

Student Signature ___________________________________________ Date __________________

Student Printed Name ____________________________Student ID#____________________

Student Medical Consent For Those 18 and Over

I, the undersigned __________________________ (student name), give my consent to receive treatment for illness or injury, medication or immunization deemed advisable through the Biola University Health Service, and to make the necessary referrals to other facilities, if indicated. I understand and agree that my Student Health History Form will be accessible by the Office of New Student Orientation and Transitions and the leaders of said activity.

I consent to any x-ray examination, laboratory test, anesthetic, medical or surgical diagnosis and hospital service that may be rendered under the general or special instruction of any licensed physician, whether such treatment or diagnosis or immunization is rendered at the office of the physician or at a licensed hospital or health department. It is understood that this consent authorizes the physician to exercise his/her best judgment as to what is best for the individual patient. This consent will remain effective during my attendance at Biola University unless revoked in writing delivered to Biola University.

Student Signature ___________________________________________ Date __________________

Student Printed Name ____________________________Student ID#____________________

Please complete the top and bottom of this form and send to:

Student Orientation Services (SOS)
Biola University
13800 Biola Ave
La Mirada, CA 90639-0001

sos.director@biola.edu
Fax: 562-906-4567