

For 18 years of age and over

Campus Crusade for Christ

Medical Authorization and Release

Mail form: Risk Management Dept. ~ CCC ~ 100 Lake Hart Dr. #3900 ~ Orlando, FL 32832

For Assistance: Call 407-826-2275 or Fax 407-826-2278

I, the undersigned, hereby agree as follows:

Your Name	X
Address (incl. County)	

In the event of any accident, sudden illness, or medical emergency involving myself in connection with the named event, I hereby authorize the following staff members of Campus Crusade for Christ, Inc. 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.

Name of Staff members:	
CCCI event location:	
This authorization is limited to the following dates:	/ / to / /

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:	

I, the undersigned ("Releasor"), hereby release, waive, discharge, covenant not to sue, agree to indemnify and hold harmless, Campus Crusade for Christ Inc. and its 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 or Releasees or otherwise, arising out of or relating to my presence or participation in the aforementioned Campus Crusade for Christ event 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 Date:	/ /
Signature:	X