



MEDICAL CONSENT FORM

- Full Name of Student
- Date of Birth
- Has my permission to receive emergency care or treatment if deemed necessary.
- Address
- Health Insurance Plan Name
- ID No
- Does the student have any existing medical conditions?
 - YES
 - NO
- Currently using medication?
 - YES
 - NO
- Is the student allergic to any medication(s)?
 - YES
 - NO
- Primary Physician Name
- Phone Number
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* It is hereby understood and agreed upon that HBCU Scholarship Ride, its customers and affiliates shall not be held responsible for any claims, losses, suits or actions arising out of acts of God, war, terrorism, strikes, damages or loss of baggage or other personal property, sickness, delay, change of airline flight schedule, or personal injury caused by persons not controlled by HBCU Scholarship Ride. Tours reserves the right to accept any person(s) as a member of the group, and to pass on to the client any Expenditures created by airline delays or other events not controlled by HBCU Scholarship Ride such as weather.

All and any medication will stay in possession of a designated chaperone.