Ritsumeikan
Asia Pacific University

Medical Consent Form

Applicant's Name: _____

Part A IMPORTANT: TO BE FILLED OUT BY THE UNIVERSITY HEALTH CENTER OR A PHYSICIAN

1. Does the above mentioned applicant currently have any illness?

   ☐YES ☐NO If YES, please provide the name of illness and a treatment status.

2. Is the applicant currently using any medication?

   ☐YES ☐NO If YES, please provide details: the name of medication, amount, the frequency of the use etc.

3. Is the applicant physically fit for the scheduled field trips, bus excursions, exposure to sunlight, etc.?

   ☐YES ☐NO If NO, please explain in detail:

Doctor name : _____

Address & Phone : _____

_____

Dates : _____

Continued on reverse

Part B To be filled out by the participant and his/her parents/guardian.

IN CASE OF EMERGENCY

First person to contact: _____ (Relationship) _____

Phone: (Country code) _____

Second person to contact: _____ (Relationship) _____

Phone: (Country code) _____

Third person to contact: _____ (Relationship) _____

Phone: (Country code) _____

Please check ☑ and fill out one of the following:

☐ We (I), (Name of Parents/Guardian) _____, consent to and authorize any medical doctor or dentist and others working under their supervision to treat (Participant's full Name) _____ for any injury or illness.

We (I) further agree to pay any and all such dental and medical costs, expenses and charges and to release and discharge and hold harmless the concerned parties, its employees and agents from and against any liability or any claim or demand arising from or connected with such medical treatment or care.

☐ We (I), (Name of Parents/Guardian) _____, do not consent to or authorize any medical doctor or dentist or others working under their supervision to treat (Participant's full Name) _____ for any injury or illness.

We (I) therefore agree to assume the risk of injury/illness to (Participant's full Name) _____ from lack of any medical care or treatment and further agree to release and discharge and hold harmless the concerned parties, its employees and agents from and against any liability and any claim or demand arising out of or in connection with said failure to provide any medical care or treatment.

Signature : _____

Date : _____

Co-signature of Parent/Guardian: _____

Date : _____