



# Campus Visit Liability Release Form

Please note that visitors will not be allowed to stay overnight on campus or ride in an Admissions Representative's vehicle until the **Liability Release Form** and **Emergency Medical Release Form** are both signed and returned to the Admissions Office. These forms may be sent in advance, or turned in when you come to campus.

If you have any questions, please contact the Admissions Office at 858-653-6740.

On this date of \_\_\_\_\_ intending to be legally bound hereby, the undersigned agrees and does hereby release from liability, and to indemnify and hold harmless, John Paul the Great Catholic University, and any of its employees or agents or students representing or related to the University as regards to Guest Visitation and Overnight Housing. This release is for any and all liability for personal injuries (including death) and property losses or damage occasioned by, or in connection with any activity or accommodations for this visit, including but not limited to public transportation and transportation in any vehicle owned or driven by a University employee or student. The undersigned further agrees to abide by all the rules and regulations promulgated by John Paul the Great Catholic University and/or its affiliate groups and vendors throughout the Campus Visit.

\_\_\_\_\_  
VISITOR NAME (PLEASE PRINT)

\_\_\_\_\_  
SIGNATURE OF VISITOR

\_\_\_ / \_\_\_ / \_\_\_  
DATE SIGNED

\_\_\_\_\_  
SIGNATURE OF PARENT / GUARDIAN (IF UNDER 18)

\_\_\_ / \_\_\_ / \_\_\_  
DATE SIGNED



# Emergency Medical Release Form

I, \_\_\_\_\_, give permission to my son / daughter \_\_\_\_\_,  
PLEASE PRINT FULL NAME PLEASE PRINT FULL NAME

to visit John Paul the Great Catholic University on the dates of \_\_\_\_\_.  
PRINT DATES OF VISIT

If needed for health reasons, I give permission for my child to be evaluated, diagnosed, treated, and/or given medication in accordance with the standard medical practice by licensed medical personnel. I relieve John Paul the Great Catholic University of all responsibility and consequences that may arise as a result of this treatment. I will not hold John Paul the Great Catholic University or any of its employees, agents, or students liable in the event of injury. Furthermore, I agree to accept any and all financial responsibility as a result of scheduling medical treatment.

My son/daughter agrees to abide by all rules and regulations stated by John Paul the Great Catholic University Staff including Admissions and Residence Life Staff. I understand that while visiting the campus my son/daughter is unchaperoned, in like manner as any University student. I understand that John Paul the Great Catholic University will not be liable if my child fails to cooperate with regulations, and that any infraction of the rules may result in immediate termination of the visit and all expenses in returning them home will be at my expense.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
SIGNATURE OF PARENT / GUARDIAN (IF UNDER 18) DATE SIGNED

*As the visiting student, I also agree to the above terms and conditions of my visit.*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
SIGNATURE OF VISITOR DATE SIGNED

Family Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medical History: \_\_\_\_\_

### IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_