



**Health Services Office**

5000 Deer Park Dr. SE  
Salem, OR 97317-9392

Phone: 503.375.7010 x2181  
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**Comprehensive Student Health and Disability Report**  
**LIABILITY RELEASE / INSURANCE INFO**

Name: \_\_\_\_\_  
*Last**First**M.I.*

**LIABILITY RELEASE**

All information on this form will be kept confidential and will be shared with appropriate Corban personnel on a need-to-know basis only. Please return your completed form to the Office of Student Life in the enclosed return envelope.

Corban University assumes no responsibility for payment of medical expenses for students who sustain injuries while enrolled at Corban. This includes injuries sustained in all college activities, including, but not limited to, injuries occurring in classes, while participating in class-sponsored activities, internship programs, community service assignments, intramural sports, inter-collegiate athletic programs, mission trips, educational excursions, or ASB sponsored events.

The undersigned acknowledges there are inherent risks of injury from participating in various school activities and waives and releases Corban University from any and all claims or demands for damages or injury, known or unknown, that the participant may have against them while a student at Corban.

If physical activity of a student has been restricted by a physician, the student is responsible for observing such restrictions.

*I have read and agree to the above statements:*

\_\_\_\_\_  
*Student signature* *Date*

\_\_\_\_\_  
*Parent/Gaurdian signature (if student is under 18)* *Date*

**INSURANCE INFORMATION**

All full-time traditional undergraduate students are required to carry health insurance and are automatically issued a policy. The premium is charged to your tuition account. If you have your own insurance and do not wish to be covered by the school insurance plan you must opt out by completing the online waiver form at [www.maksin.com/Corban.aspx](http://www.maksin.com/Corban.aspx).

The insurance information below is for the benefit of Corban Health Services and does not replace the need for you to opt out of the school insurance plan as described above.

Name of Health Insurance Company: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Policy Number(s): \_\_\_\_\_

\*Name of Insured: \_\_\_\_\_ \*Insured's Date of Birth: \_\_\_\_\_

Employer of Insured: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

*\*Usually applies to parent who carries the policy*

**Please attach a photocopy of front and back of insurance card**

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

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

Last tetanus shot: \_\_\_\_\_