Medical Liability Release Form

DIRECTIONS: Due to legal restrictions, it is necessary that **all** delegates (student members), parents/guardians, guests, chaperones and **HOSA Advisors** complete this form to be eligible to attend the 2020 HOSA State/International Leadership Conferences. This form should be returned to the HOSA Local Chapter Advisor who will forward all **original** forms to the State Advisor. In turn, the HOSA State Advisor will make a copy for his/her files and mail the original forms to National HOSA.

PLEASE TYPE OR PRINT ALL INFORMATION

Delegate (student/advisor/guest) *Parent/Guardian*

Name _____Name_____

Home Address_____

Parent/Guardian/Telephone: Home: _____Work:_____

Delegate's Physician: _____Phone: _____

Physician's Address: _____

Alternate Contact: _____

Telephone Number: Home: _____Work:_____

Local Advisor: _____School Name/Principal: _____

Student is covered by group or medical insurance: _____ Yes _____ No

If yes, complete the following information:

Name of insured: _____Insurance Company: _____

Group #: _____Policy #: _____

Please completely describe any medical condition which may recur or be a factor in medical treatment:

a. Allergies: _____ e. Physical Handicap: _____

b. Convulsions: _____ f. Medicine Reactions: _____

c. Blackouts: _____ g. Disease of any kind: _____

d. Heart/lung problems: _____ h. Other (Be specific):_____

If currently taking medication, please provide the following information:

Name of medication: _____ Prescribing Physician/Phone Number: _____

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LIABILITY RELEASE. I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her own insurance coverage during this trip. I hereby release the National HOSA Board of Directors, the National Staff, State and Local HOSA Associations, and any designated individual in charge of the HOSA group or specific activity from any legal or financial responsibility with respect to my personal or my student/child's participation in or contact with any known element associated with an activity including competitive events.

PARENT/GUARDIAN/ADVISOR/ADULTSTUDENTMEMBER/GUEST: Please check one of the following and sign your name.

☐ I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.

☐ I do not give permission for medical treatment until I have been contacted.

Delegate's Signature: _____ Date _____

(Refers to: Secondary member/PS/C student member/advisor/guest/chaperone/family member)

Parent/Guardian's Signature: _____ Date _____

(Not required for post-secondary members)

Advisor's Signature: _____ Date _____

School/Chapter Name: _____