

Medical Liability Release Form

DIRECTIONS: Due to legal restrictions, it is necessary that all delegates, parents/guardians, guests and HOSA Advisors complete this form to be eligible to attend any 2022-2023 NE HOSA Experiences or Conferences. This form should be in the possession of the local Chapter Advisor before delegates, parents/guardians, guests, and HOSA Advisors attend SLC. The local Chapter Advisor should have access to these forms when they attend SLC.

PLEASE TYPE OR PRINT ALL INFORMATION

Delegate Parent/Guardian

Name _____ Name _____

Home Address _____

Parent/Guardian: Home#: _____ Work#: _____

Student's Physician: _____ Phone: _____

Physician's Address: _____

Alternate Contact: _____

Telephone #: Home: _____ Work: _____

Local Advisor: _____ School Name: _____

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 issues: _____ h. Other (Be specific): _____

If currently taking medication, please provide the following information:

Name of medication: _____

Prescribing Physician/Phone Number: _____

LIABILITY RELEASE. I certify that the information on page 1 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 HOSA Board of Directors, the HOSA 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: 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.

Parent/Guardian's Signature: _____ Date _____
(Applicable for delegates under the age of 18 and must be signed by the parent or legal guardian.)

Delegate's Signature: _____ Date _____

Advisor's Signature: _____ Date _____