

# 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 the HOSA International Leadership Conference. This form should be returned to the HOSA Chapter Advisor who will forward all 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 HOSA-Future Health Professionals. Please check with your state advisor for the state due date, which will be prior to May 15.

## PLEASE TYPE OR PRINT ALL INFORMATION

*Delegate Parent/Guardian*

Delegate Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Parent/Guardian Cell# \_\_\_\_\_

Home Address \_\_\_\_\_

Parent/Guardian/Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_

Student's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Alternate Contact \_\_\_\_\_

Telephone Number 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 problems \_\_\_\_\_ h. Other (Be specific) \_\_\_\_\_

If currently taking medication, please provide the following information:

Name of medication \_\_\_\_\_ Physician/Phone Number \_\_\_\_\_

**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 HOSA, Inc. Board of Directors, the HOSA-Future Health Professionals 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 \_\_\_\_\_

School \_\_\_\_\_