State 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 HOSA events. This form should be returned to the HOSA Chapter Advisor who will forward a copy of all forms to the State Advisor. In turn, the HOSA State Advisor will make a copy for his/her files.

PLEASE TYPE OR PRINT ALL INFORMATION

Delegate Information

Name ____School______________________________________

Home Address____

City, State, Zip ____

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: _________________________Prescribing 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 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: 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 Name: ____ Relation:__________________

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 _________________