**New York State/National HOSA/HWNY**

**Advisor’s, Chaperone’s, and Guest’s CODE OF ETHICS**

***This form is due upon arrival***

**HOSA/HWNY ADVISORS AND CHAPERONES ARE EXPECTED TO:**

1. Project a positive and professional image of NYS HOSA/HWNY to all those with whom

you interact.

1. Promote HOSA/HWNY as a positive student experience; therefore, will act as a positive

role model for students in dress, voice, attitude, actions, and demeanor.

1. Remain accountable to and for your students in all HOSA/HWNY-related activities.
2. Understand and follow established processes within the HOSA/HWNY organization that

protect the rights of all members.

1. PERFORM all assigned duties and assist wherever possible. Failure of an advisor to perform their

Duties and assist wherever possible may result in their chapter being disqualified from conference

activities by the Board of Directors.

HOSA/HWNY advisors chaperones, guests are proud of the standard of excellence they maintain for themselves, and their students. Attendance at any HOSA/HWNY function implies acceptance and practice of these standards.

I have read the above Code of Ethics for HOSA/HWNY Advisors/Chaperones/Guests and agree to accept and practice these standards.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please check one:

**Advisor: \_\_\_\_\_\_\_ Chaperone: \_\_\_\_\_\_ Guest: \_\_\_\_\_\_**

**School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOTE:**

Due to legal restrictions, it is necessary that all members, parents/guardians, guests and HOSA Advisors complete this form to be eligible to attend the HOSA New York State / National Leadership Conference. *This form should be submitted by the Chapter Advisor during the conference registration process and please make a copy for your records. Form good for the 2017-2087 school year.* ***This form is due upon arrival.***

* ***FAILURE TO HAND THIS FORM IN DURING THE REGISTRATION PROCESS WILL RESULT IN YOUR ENTIRE SCHOOL DELEGATION BEING SENT HOME (at the school’s expense).***

**Medical Liability Release Form**

**DIRECTIONS:** Due to legal restrictions, it is necessary that all members, parents/guardians, guests and HOSA/HWNY Advisors complete this form to be eligible to attend the HOSA/HWNY New York State/National Leadership Conference. *This form should be submitted by the Chapter Advisor during the conference registration process and please make a copy for your records. Form good for the 2017-2018 school year.* ***This form is due upon arrival. FAILURE TO HAND THIS FORM IN DURING THE REGISTRATION PROCESS WILL RESULT IN YOUR ENTIRE SCHOOL DELEGATION BEING SENT HOME (at the school’s expense).***

**PLEASE TYPE OR PRINT ALL INFORMATION**

*Member/Guest 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: \_\_\_\_\_\_\_\_\_\_\_

Attach list of medications if necessary.

**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/HWNY Associations, and any designated individual in charge of the HOSA/HWNY 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 participants under the age of 18 and must be signed by the parent or legal guardian.)

Delegate’s(Student) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Advisor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Photo Liability Release Form**

**NEW YORK STATE HOSA/HWNY LEADERSHIP CONFERENCES**

**2017-2018 School Year**

**I give permission for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be photographed during the New York State Leadership Conferences. These photos may be used on but not limited to the New York HOSA Website.**

**Please visit our website at** [**www.newyorkhosa.org**](http://www.newyorkhosa.org)

**Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_**

**Student’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_**

**Advisor’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_

**School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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