Medical Liability Release Form

DIRECTIONS: Due to legal restrictions, it is necessary that **all** New York State HOSA members/advisors complete this form to be eligible to attend the New York State HOSA Leadership Conferences and Meetings.. This form should be returned to the HOSA Chapter Advisor who will forward the scanned copies of the forms to the State Advisor. In turn, the HOSA State Advisor will make a copy for his/her files. Please check with your state advisor for the state due date, which will be prior to any Meetings or Conference.

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 ____