Do NOT leave blank answers on this page. If a question does not apply to you, please respond with "N/A"

SC HOSA
2025 State Leadership Conference
Medical Liability Release Form

Because of legal restrictions, every conference attendee (students, advisors, chaperones, parents/guardians, and guests) must fill out this form before being allowed to join an SC HOSA-sponsored event/activity.

Please TYPE or PRINT.
NO electronic signatures will be accepted. Forms should be turned in at the SLC Registration table.

HOSA Activity: **2025 State Leadership Conference**

Location: **North Charleston, SC** Event Dates: **March 5 -7, 2025**

Participant's Name:_____

School:_____

Advisor:_____ Student's Parent/Guardian Name:_____
Print name

Home Address:_____City/State/Zip:_____

Are you covered by Medical Insurance? ☐Yes ☐No If yes, name of Insured: _____

Phone number of Insured: (____)_____ Insurance Co Name:_____

Group Number: _____ Policy Number: _____

Allergies or reactions to any medications:_____

List any medications & dosage you are currently taking_____

_____

Are there any diseases/illnesses we should be aware of? _____

PARENT/GUARDIAN: Please check one of the following:

☐ I give permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any person listed above as soon as possible.

☐ I do not give permission for emergency medical treatment until I have been notified.

LIABILITY RELEASE: I certify the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her insurance coverage and medical expenses incurred on this trip. I hereby release the school, the HOSA Chapter, SC HOSA, Inc., and any adult in charge of the group from any legal or financial responsibility, due to any injury or illness, including all communicable diseases.

Parent/Guardian's Signature: _____ Date: _____

Student's Signature_____Date:_____

ADVISOR: I am responsible for and should follow the field trip care plan and if needed, the emergency health plan for every student in my care.

Advisor Signature: _____ Date:_____

***Required parent signature for all students in High School. NO ELECTRONIC SIGNTURES Will Be Accepted.**