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 _____