



# SOUTH CAROLINA HOSA MEDICAL LIABILITY RELEASE FORM



DIRECTIONS: Due to legal restrictions, it is necessary that **all conference attendees: students, parents/guardians, guests, and HOSA advisors** complete this form as a prerequisite for eligibility to participate in a South Carolina HOSA sponsored activity. PLEASE TYPE OR PRINT. Forms should be turned in at SLC Registration.

HOSA Activity : **2021 State Leadership Conference** Location: **North Charleston, SC**

Date: \_\_\_\_\_

Participant's Name \_\_\_\_\_ School: \_\_\_\_\_

Advisor \_\_\_\_\_

Parent/Guardian's Name (for students) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Phone: Parents' Work (\_\_\_\_) \_\_\_\_\_

Emergency Contact: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Physician \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Are you covered by medical insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, name of insured: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Allergies or reactions to any medications: \_\_\_\_\_

Physical handicaps: \_\_\_\_\_

Convulsions/Seizures: Yes \_\_\_\_\_ No \_\_\_\_\_ Blackouts/Fainting: Yes \_\_\_\_\_ No \_\_\_\_\_

Diseases/Illness: \_\_\_\_\_

Heart or Lungproblems: Yes \_\_\_\_\_ No \_\_\_\_\_ if yes, describe: \_\_\_\_\_

Other: \_\_\_\_\_

If currently taking medication, please provide the following information:

a. Name of Medication(s) \_\_\_\_\_

b. Prescribing Physician \_\_\_\_\_

c. Physician's Phone (\_\_\_\_) \_\_\_\_\_

PARENT/GUARDIAN: Please check one of the following and sign your name.

\_\_\_\_ A. I give 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.

\_\_\_\_ B. I do not give permission for emergency medical treatment until I have been notified.

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 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.

**Parent/Guardian's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Student's Signature** \_\_\_\_\_

**Advisor's Signature:** \_\_\_\_\_

**Advisor's Initials** \_\_\_\_\_ 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.