



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. **Be sure to indicate "N/A" for any items that do not apply.**

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's Signature _____ Date: _____

(For all Middle and High School students, a parent or legal guardian must provide a signature, regardless of the student's age. Any post-secondary students under the age of 18 are required to have a parent or legal guardian's signature.)

Delegate's Signature _____ Date _____

Advisor's Signature _____ Date _____

School _____