Montana HOSA Medical Liability Release Form

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 Montana HOSA Conferences. This form should be returned to the HOSA Chapter Advisor who will forward all forms to the State Director. In turn, the HOSA State Director will make a copy for his/her files and mail the original forms to National HOSA.* Please check with your State Director for annual due date. *Submitted to National for ILC only.

Please type or print all information

Delegate Parent/Guardian Name _____ Name _____

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 National HOSA Board of Directors, the National Staff, State and Local HOSA Associations, Carroll College, 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 _____