

APPENDIX V
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.

Student/Delegate Information

Name Date of Birth:

Cell Phone:

Parent/Guardia(s) Information

Name Relation:

Phone Home Cell:

Name Relation Phone Home Cell:

School Information

School Name State:

Local Advisor:

Phone Work Cell:

Medical Provider

Physician Name Phone

Address

Is the individual covered by group or medical insurance: Yes No

Name of Insured:

Insurance Company:

Group Number Policy Number:

Please completely describe any medical condition which may recur or be a factor in medical treatment:

- a. Allergies
- b. Physical Handicap
- c. Convulsions
- d. Medicine Reactions
- e. Blackouts
- f. Disease of any kind
- g. Heart/lung issues
- h. Other (Be specific)

If currently taking medication, please provide the following information:

Name of medication:

Prescribing Physician/Phone Number:

LIABILITY RELEASE. I certify that the information on this form is accurate and complete to the best of my knowledge. I understand each individual is responsible for his/her own insurance coverage during this trip. I hereby release the HOSA Board of Directors, the HOSA 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: