STUDENT PERMISSION/MEDICAL RELEASE FORM

Code of Conduct Agreement, Permission to Participate in Activities, Media Authorization, Release of Liability, and Emergency Medical Treatment Authorization:

Student Information

Name: _____ Date of Birth: _____

Address:_____ City:_____

City:_____ State:_____ Zip Code: _____

Email: _____ Phone Number: _____

High School: _____Advisor: _____

Parent/Guardian Information

Name: _____ Phone:_____

Cell Phone: _____ Work Number: _____

Email: _____

This is to certify that _____ has my permission to attend all ***HOSA*** sponsored activities for the 2026-2027 State Executive Council Term. I also release ***HOSA,*** the school officials, the ***HOSA*** chapter advisors, conference staff, and ***HOSA*** staff and volunteers from any claims for personal injuries/damages which might be sustained while (s)he is traveling to and from an event or during a HOSA sponsored activity.

I give permission to ***HOSA*** and its staff, volunteers, and sponsors, and local or state Department of Education to use the student's name and likeness (including photos, videos or quotes) in publications, productions, social media and on websites for informational, promotional or other **HOSA** purposes without further contact.

I acknowledge and understand that the chapter advisor establishes the guidelines for individual students to attend and participate in all ***HOSA*** events.

I authorize the above-named advisor or ***HOSA*** staff to secure the services of a doctor or hospital for _____. I will pay the expenses for necessary services in the event of an accident or illness.

We have read and agree to abide by the supplied ***HOSA*** Code of Conduct. Should a Code of Conduct violation occur, law enforcement personnel and or security may be called. A student in violation of this Code of Conduct may be disqualified and sent home at his or her family's expense and membership may be revoked. If the student is an officer, a violation may result in removal from office. If the student is sent home, all measures will be used to secure a safe and financially sound method of travel home.

Student Signature_____ Date:_____

Parent/ Guardian Signature: _____ Date: _____

Chapter Advisor Signature: _____ Date: _____

MEDICAL INFORMATION

Known Allergies (drug or natural):

_____

_____

_____

Current Medication:

_____

_____

_____

History of:

- ☐ Heart Condition
- ☐ Diabetes
- ☐ Asthma
- ☐ Epilepsy
- ☐ Other Chronic Condition

Any Physical Restrictions?:

_____

Other Conditions?:

_____

Primary Care Physician _____Phone: _____

INSURANCE INFORMATION

Company: _____ Name of insured: _____

Group #: _____ Policy #: _____

Insurance Phone Number: _____

*Please attach a copy of your insurance card.