

**EMERGENCY MEDICAL TREATMENT AUTHORIZATION
RELEASE OF CLAIM FOR DAMAGES**

NAME OF STUDENT _____ DATE _____

HOME ADDRESS _____

DATE OF BIRTH _____ HOME PHONE _____

NAME OF HIGH SCHOOL _____ PHONE _____

I do hereby, on behalf of **THE ABOVE NAMED STUDENT**, absolve and release the school officials, the HOSA chapter advisors and the state HOSA staff from any claims for personal injuries which might be sustained while he/she is in route to and from or during the HOSA sponsored activity.

I authorize the chapter advisor or state HOSA staff to secure the services of a doctor or hospital. I will incur the expenses for necessary services in the event of accident or illness and provide for the payment of these costs.

Parent/Guardian Signature Date

Parent/Guardian Signature Date

MEDICAL INFORMATION:

Known allergies (drug or natural) _____

Special medication being taken: _____

Date of last tetanus shot: _____

History of heart condition, diabetes, asthma, epilepsy or rheumatic fever: _____

Any physical restrictions: _____

Other conditions: _____

Family Doctor: _____ Phone _____

Parent or guardian phone: *Work* _____ *Home* _____ *Other* _____

INSURANCE INFORMATION

Insurance Company Name _____ Policy Number _____

Coverage: _____