



MEDICAL INFORMATION FORM

Louisiana State Leadership Conference

March 2 - 3, 2020

This form MUST be returned with the registration form to your Chapter Advisor.

Student Name: _____ **Age:** _____

Address: _____

City: _____ **Zip Code:** _____

Home Phone: (_____) _____ **Cell phone:** (_____) _____

Mother/Guardian: _____ **Phone:** (_____) _____

Workplace: _____ **Phone:** (_____) _____

Cell phone: (_____) _____

Father/Guardian: _____ **Phone:** (_____) _____

Workplace: _____ **Phone:** (_____) _____

Cell phone: (_____) _____

Other Emergency Contact: _____ **Phone:** (_____) _____

STUDENT MEDICAL INFORMATION [Check only if condition(s) are present or recurring]. Failure to disclose a medical condition that could be life-threatening or interfere with conference activities may result in dismissal of the student.

_____ Diabetes _____ Asthma _____ Heart Condition
_____ Hemophiliac _____ Epilepsy/Seizures _____ Other (please explain below)

If any of the above conditions are checked, please explain. _____

Allergies: _____

Is student on any type of medication? ____ Yes ____ No May student self-medicate? ____ Yes ____ No

If yes, what medication and dosage? _____

I understand that if this form is not received by the deadline, the student will not be eligible to attend the conference. In case of an accident or serious health emergency, I hereby authorize the School District or Louisiana HOSA to make whatever arrangements are necessary and to contact me or listed adults immediately. I authorize trained personnel to render treatment deemed necessary in case of an emergency and for medical information to be shared with appropriate personnel. I understand that it remains my responsibility to make any future information changes on this medical information form, by contacting Shirlene Bender (Louisiana HOSA State Advisor), at 337-371-5974. Otherwise, this authorization remains in effect as of this date until program completion. Neither Louisiana HOSA, Louisiana HOSA Board of Directors, nor National HOSA assumes responsibility for any medical charges including emergency transportation.

Parent's or Guardian's Signature

Date

Print Parent name

Advisors: Please return this form with registration.