MEDICAL INFORMATION FORM

Louisiana State Leadership Conference

February 27-29, 2016

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

Student Name: ____ Age: __________

Address: ____

City: ____ Zip Code: ____________

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
_______ Hemophiliac
_______ Neuro/Muscular Problem
_______ Asthma
_______ Hearing Aid
_______ Allergy
_______ Heart Condition
_______ Wears Glasses/Contacts
_______ Other (please list below)

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

____

Is student on any type of medication? _____ Yes _____ No May student self-medicate? ____Yes ____No

If yes, what type 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 condition, I hereby authorize hospital officials to make whatever arrangements are necessary and to contact me immediately. I understand that it remains my responsibility to make any future information changes on this medical information form as the need arises, by contacting Shirlene Bender (Louisiana HOSA State Advisor) at 337-989-0001. Otherwise, this authorization remains in effect as of this date, until program completion. Neither Southwest Louisiana Area Health Education Center or Louisiana HOSA, nor Louisiana HOSA Board of Directors, nor National HOSA assumes responsibility for any medical charges.

____ ____________

Parent's or Guardian's Signature Date

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Print Parent name

Advisors: Please return this form with registration.