PERMISSION, MEDICAL / EMERGENCY TREATMENT & PHOTO RELEASE - SIGN OFF SHEET

I certify that the following forms are complete and that I will retain the original forms for each person attending the Delaware Fall Leadership Conference.

➢ Parent or Guardian Permission _________________ (Advisor initial)
➢ Medical / Emergency Treatment _________________ (Advisor initial)
➢ Parental Authorization for Photo Release _________________ (Advisor initial)

_________________________________________  __________________________
CTSO Advisor (print name)  School Name

_________________________________________  __________________________
CTSO Advisor (signature)  Date

* The parent(s)/guardian(s) of the student(s) listed do not grant permission to the Delaware Department of Education to use their child’s picture for publication.

_________________________________________  __________________________________
_________________________________________  __________________________________
_________________________________________  __________________________________
_________________________________________  __________________________________

Please provide this signed form at the conference registration table upon arrival
STUDENT PERMISSION
Medical Emergency Treatment

PARENT OR GUARDIAN PERMISSION

____________________________________________________ has my permission to attend and participate in the
2017 Fall Leadership Conference. I understand the Delaware delegation will be traveling by bus/student/family
car/plane. My child has been made aware that they are to obey the rules of the Delaware delegation and of the
supervisors assigned to them. If there is some reason my child needs medical attention or for some disciplinary
reasons must be sent home, I will be contacted.

____________________________________________________
Signature of Parent or Guardian

Date

Medical Data
List any allergies, illnesses, and/or medical conditions for which medicine, treatment, and/or other accommodations
may be needed during the conference period**

Allergies, illnesses, and/or medical conditions:

Type of Medicine carried:

Currently being treated for:

Name and address of family physician:

Physician’s phone:

Name and address of person to contact in case of illness:

Contact person’s phone:

Insurance Plan Name:

Insurance ID#/Group #:

**Any medical conditions, illnesses, and/or allergies must be brought to the attention of the CTSO State Advisor at least one
week prior to attendance in any state CTSO activity or four weeks prior to any national CTSO event. The local CTSO advisor(s) is
responsible for making arrangements to meet the health needs, including medication administration and storage for his/her
students. Only a registered nurse may administer medications, with the exception of an educator who may be trained to assist
with self-administration. Districts retain full responsibility to adhere to district policies and procedures regarding administration
of medications and/or medical treatments for students in their delegations throughout the CTSO activity. Advisors should carry
the original Medical/Permission forms when en route to, from or during any CTSO conference, event, or activity.
STUDENT PERMISSION/
Medical Emergency Treatment

I, ____________________________________________ (Parent/Guardian’s Name)

of ____________________________________________ (Name of HOSA Participant)

(Parent/Guardian’s Name) (Relationship)

(Name of HOSA Participant) (Age)

Complete Home Address: (including Zip)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

(Area code and Home telephone No.)

________________________________________________________________________

(Area code and Work telephone No.)

I hereby authorize in advance the advisor/CTSO representative to secure the services of a physician or hospital, and to incur the expenses for necessary services in the event of accident or illness, and I will provide for the payment of these costs.

I also do hereby on behalf of him/her absolve and release the school officials, the CTSO chapter advisors and the assigned state/provincial CTSO staff from any claims for personal injuries or illness which might be sustained while he/she is en route to and from or during any DE CTSO sponsored activity.

Medical/hospitalization carrier policy number: ____________________________________________

Other Medical Insurance: ____________________________________________

Policy Number: ____________________________________________

I also agree that the school officials, the CTSO chapter advisors, the state/provincial CTSO staff, or the Conference Conduct Committee members have the right to send my child home from the activity at our expense, provided that he/she has violated the Code of Conduct and/or his/her conduct has become a detriment.

________________________________________

(Parent/Guardian’s Signature)

Advisors should carry the original Medical/Permission forms when en route to, from or during any CTSO conference, event, or activity.
Parental Authorization
Photo Release Form

Please check one:

_____ I hereby GRANT PERMISSION to the Delaware Department of Education to use my child’s picture for publication. I release and indemnify the Delaware Department of Education from and against any claims or causes of action that I or my child may have against the Department of Education, invasion of my child’s right of privacy, or any other manner in any way connected with the use or publication of the photographs taken by the Department of Education.

_____ I DO NOT wish to grant permission to the Delaware Department of Education to use my child’s picture for publication.

_______________________________________  ______________  ______________
Parent/Guardian’s signature                     Date

_______________________________________  __________________________
Parent/Guardian’s printed name                      Relationship to student

_______________________________________  ______________
Signature of student                             Date

_______________________________________
Student’s printed name