EMERGENCY MEDICAL TREATMENT

(PARENT CONSENT FORM)

NOTE: Chapter Advisors are to keep this original and to Return a Photo copy for each Student **or *Return a completed copy of the Conference Sign-off Sheet your conference registration information.***

I, _____

(Parent/Guardian's Name) (Relationship)

of _____

(Name of Participant) (Age)

Complete Home Address: _____

(including Zip): _____

Home Phone: _____ Work Phone: _____ Pager/Cell Phone: _____

hereby authorize in advance the advisor/DECA 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 DECA chapter advisors and the assigned state DECA staff from any claims for personal injuries or illness which might be sustained while he/she is en route to and from or during the DECA sponsored activity.

Insurance Company: _____

Medical/hospitalization carrier policy number: _____

Other Medical Insurance: _____

Policy Number: _____

If you do not have any medical insurance, please sign here that you will be responsible for medical bills: _____

Family Physician Name: _____ Phone Number: _____

Physician's Address: _____

Please list any known
Allergies or write "NO ALLERGIES": _____

Please list any medications that you are
taking or write "NO MEDICATIONS": _____

Please list any pre-existing medical conditions
and/or physical limitations or write "NO": _____

_____

(Parent/Guardian Signature)

_____

(Date)

_____

(Notary's Signature & Seal)

_____

(Date

**** Chapter Advisor(s) should always carry a copy of their student(s) Medical and Permission forms when traveling.***