MEDICAL INFORMATION FORM

For all HOSA events

2024-2025

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

Student Name: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ Zip Code: _____

Cell Phone: (_____)_____ Other phone: (_____)_____

Mother/Guardian Name: _____

Workplace: _____ Phone: (_____)_____

Cell phone: (_____)_____

Father/Guardian Name: _____

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 (in the case of an emergency, this form will be given to medical attendant; all medications must be disclosed)? _____

_____

I understand that if this form is not received by the chapter advisor, the student will not be eligible to attend any HOSA events. In case of an accident or any health emergency during events, I hereby authorize the School District or Louisiana HOSA representative 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 the chapter advisor or Shirlene Bender (Louisiana HOSA State Advisor), at 337-371-5974. Otherwise, this authorization remains in effect as of this date until program completion at the end of the school year. 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 Keep this form for the entire year; bring this form to HOSA events.