

Student Member Release Form *For Michigan HOSA State Officers*

Name of Student _____ Social Security # _____

Home Address _____ Phone _____

_____ Date of Birth _____

High School _____ H.S. Phone _____

Chapter Advisor _____ H.S. Fax _____

This is to certify that _____ has my permission to attend HOSA activities from April 16, 2025 – June 30, 2026. On behalf of the above-named student member, I hereby absolve and release the school officials, the HOSA chapter advisors, Michigan HOSA, the host state, and/or the HOSA conference staff from any claims for personal injuries which might be sustained while he/she is en route to and from or during such HOSA sponsored activities providing that this agreement shall not apply to any injury arising out of sole negligence of the preceding parties.

I authorize the above named advisor(s), the Michigan HOSA State Director and/or his designee to secure the services of a physician or hospital and to incur the expenses for necessary services in the event of an accident or illness, and I will provide the payment of these costs.

We have read and agree to abide by the supplied Michigan HOSA Code of Conduct (in the Michigan HOSA Guide) and the State Officer Code of Conduct. Should a Code of Conduct violation occur, law enforcement personnel and/or security may be called to assist, with the ultimate punishment of being sent home at the student's or chapter's expense and/or being removed from office. Reasonable care shall be exercised to ensure the safest, most expedient, and financially feasible mode of transportation back to the home community of the student involved. I am aware of the consequences that will result from violation of any of the guidelines.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Chapter Advisor Signature _____ Date _____

REQUIRED MEDICAL INFORMATION

Known allergies (drug or natural) _____

Special Medication being taken _____

Date of last tetanus shot _____

History of heart condition, diabetes, asthma, epilepsy or rheumatic fever _____

Physical restrictions _____

Other conditions _____

Family Doctor _____ Phone _____

Parent/Guardian Phone: Work _____ Home _____

Insurance Company Name _____ Policy # _____