Business Professionals of America, Indiana Association

Medical Release Form and Agreement to Accept Financial Responsibility

Please **PRINT** and use **BLACK** ink.

Part 1

The purpose of this form is to authorize the provision of emergency treatment for chapter members in the unlikely event that they become ill or injured while traveling to/from a conference. It is imperative the following information be furnished so that the member will be cared for properly.

The authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concur in the necessity for such surgery, are obtained prior to the performance of such surgery.

I,_____(Name) of_____(Address) (City) (State, Zip),

hereby give my consent for: (1) the administration of any emergency treatment deemed necessary by a licensed physician or dentist, (2) the transfer to any hospital reasonably accessible, (3) consent to release the medical information provided, and (4) I (we) further agree that I (we) will assume all expenses involved in such medical/dental procedures and will not hold the Business Professionals of America, Indiana Association, or its representatives liable for said expenses.

_____ Date_____/_____/_____
(Member's Signature) (Month) (Day) (Year)

_____ _____
(Alternative Contact's Name) (Alternative Contact's Number)

The following information is needed by any hospital or practitioner not having access to the member's medical history:

Does the member have:	**ANY ITEMS MARKED "YES" SHOULD BE EXPLAINED BELOW**	
1. Any allergies		
FOOD	_____YES	_____NO
MEDICATION	_____YES	_____NO
OTHER (insect, etc.)	_____YES	_____NO
2. Any health problems or physical disabilities	_____YES	_____NO
3. Any respiratory problems	_____YES	_____NO
4. Any diabetes	_____YES	_____NO
5. Any epilepsy	_____YES	_____NO
6. Any chronic disease	_____YES	_____NO
7. Any emotional or psychological problems	_____YES	_____NO
8. Any medication being taken at present	_____YES	_____NO

9. Any Glasses YES/NO , Contact Lenses YES/NO , Hearing Devices YES/NO worn?

If any of the above questions are marked "YES," please explain. If taking medication, please give name, amount of dosage, and time medication is taken.

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10. Name of family physician: Number: Address:

PART II-REFUSAL OF CONSENT
DO NOT COMPLETE PART II IF YOU COMPLETED PART I

I do **not** give my consent for emergency medical treatment. In the event of illness or injury requiring emergency treatment, I wish the authorities to take no action or to: _____

_____

_____ Date_____/_____/_____
(Member's Signature) (Month) (Day) (Year)

_____, _____
(Member's Name) (Street Address)

_____
(City) (State) (Zip)

The above signed being member of a youth organization known as the Business Professionals of America, Indiana Association, hereby agrees to release the Vocational Education Section, its representatives, agents, servants and employees from liability for any injury to said member, resulting from any cause whatsoever occurring to said member, resulting from any cause whatsoever occurring to said member at any time while attending convention(s) or meetings of the Vocational Education Section, including travel to and from the said meeting, excepting only such injury or damage resulting from the willful acts of such representatives, agents, servants, and employees.

_____
Member Signature Date