**FCCLA** 

**Medical Release Form**

Name of Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Food Allergies/Physical Restrictions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adviser \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

Health Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   
Policy Holder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Known allergies (drug or natural) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date last tetanus shot \_\_\_\_\_\_\_\_\_\_\_

Medication being taken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ History of heart condition/diabetes/asthma/epilepsy/rheumatic fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I, the parent/guardian do hereby grant permission and certify that the above named student has my permission to attend the 2021-2022 local, region, state and national activities hosted by Acorn FCCLA and FCCLA, Inc**. I also do hereby on behalf of him/her absolve and release school officials, FCCLA chapter advisers, and FCCLA state/national association staff from any claims for personal injuries or illness which might be sustained while he/she is traveling to and from and in attendance at local, region, state, & national events.

In the event of an emergency, I do voluntarily authorize medical services to be administered and/or obtained for the above named student as deemed necessary in medical judgment and in accordance with the above confidential information. I authorize the chapter adviser or other chaperoning adult to secure the services of a physician or hospital, and to incur the expense for necessary services in the event of accident or illness, and I will provide payment for these costs. I understand that, when necessary, in the event of an emergent illness or injury, delegates will   
be transported to a local medical facility at the choice of the emergency medical professionals who respond.

**Printed Name of Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
 Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**