

Emergency Medical Treatment Authorization Form



Name of Student: _____	Date: _____
Home Address: _____	Home Phone: _____
Parent/Guardian Daytime Phone Number: _____	Evening Number: _____
Name of High School: _____	School Phone: _____
Name of Activity: _____	
Advisor(s) in Charge: _____	

This is to certify that *the above named student* has my permission to attend the above named DECA activity. I also do hereby, on the behalf of *the above named student* absolve and release the school officials, the DECA chapter advisors and the DECA staff from any claims for personal injuries which might be sustained while he/she is in route to and from or during the DECA sponsored activity.

I authorize the above named advisor or DECA staff to secure the services of a doctor or hospital. I will incur the expenses for necessary services in the event of accident or illness and provide for the payment of these costs.

My student and I have read and agree to abide by the Oregon DECA Participant Code of Conduct. I also agree that that the school officials, the DECA chapter advisors, and the state DECA staff or the Conference Conduct Committee, have the right to send my student home from the activity at my expense, provided that in their opinion the seriousness of the violation of the Participant Code of Conduct warrants it.

Medical Information

Known allergies (drug or natural) _____

Is student on special medication? (if so, please list) _____

Does student have a history of: heart condition, asthma, and/or epilepsy? _____

Does your student have any physical restrictions or other conditions that should be known?

(if so, please list) _____

Student's Date of Birth: _____

Family Physician: _____ Phone: _____

Insurance Company: _____ Policy Number: _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Chapter Advisor Signature: _____ Date: _____

School Official Signature: _____ Date: _____