

# State Officer Emergency Medical Treatment Authorization Form

# 5

Name of Student: \_\_\_\_\_ Date: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Parent/Guardian Daytime Phone Number: \_\_\_\_\_ Evening Number: \_\_\_\_\_  
 Name of High School: \_\_\_\_\_ School Phone: \_\_\_\_\_  
 Name of Activity: **All DECA Sponsored Activities – February 2010- March 2011**  
 Advisor(s) in Charge: **Trina Lee, Executive Director, Brycen Woodley and State Officer Coaches**

This is to certify that *the above named student* has my permission to attend all Oregon DECA sponsored activities. I understand that the chapter advisor determines the criteria at the local site for individual students and alumni to attend and participate in all DECA activities. I also do hereby, on the behalf of *the above named student* absolve and release Oregon DECA, the school officials, the DECA chapter advisors, conference staff and Oregon DECA staff from any claims for personal injuries/damages 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 Oregon DECA staff to secure the services of a doctor or hospital for the above name student. I will incur the expenses for necessary services in the event of accident or illness and provide for the payment of these costs.

We have read and agree to abide by the Oregon DECA Participant Code of Conduct. Should a conduct code violation occur, law enforcement personnel and/or security may be called to assist, and a conduct code committee may be called with the ultimate punishment being that he student may be disqualified and sent home at their/their family's expense and/or be removed from office if in an officer status. If the delegate is sent home, reasonable care shall be exercised to ensure a safe and expedient transportation back to the home community of the student involved. We are aware of the consequences that will result from violation of any of the above guidelines.

## 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: \_\_\_\_\_