NOTE: Sample health form that can be adapted for use by local advisors

____________________ FAMILY, CAREER & COMMUNITY LEADERS OF AMERICA
(local chapter name) **Medical Release Form**

I, ______________________________ of ______________________________
Parent/Guardian Name Address
______________________________ am the ____________ of ______________________
City State ZIP Relation Member's Name
of ______________________________ .
City State ZIP

I hereby give my consent, in the event all reasonable attempts to contact me have been unsuccessful, for immediate medical treatment as required in the judgment of the attending physician while ______________________________ is absent from home ____________ to ____________ .
date date

Member's Date of Birth: ____________________ Social Security Number (optional): ____________________

Parent/Guardian Phone Number(s):Work:(____) ____________________ (____) ____________________

Home:(____) ____________________ (____) ____________________

Family Physician: ____________________ Family Dentist: ____________________

Address: ____________________ ____________________
Street Street

____________________ ____________________
City State ZIP City State ZIP

Phone:(____) __________ (____) __________ (____) __________ (____) __________
Work Home Work Home

Medical Insurance Company ____________________ Policy Number: ____________________

Name of Insured: ______________________________

The following information is needed by any hospital or practitioner not having access to a medical history:

Allergies: ______________________________

Medication being taken: ______________________________

Date of last tetanus shot: ______________________________

Physical impairments: ______________________________

Other pertinent facts to which physician should be alerted: ______________________________

____

____

(over)

If parent/guardian cannot be reached in case of emergency, call:

_____________________________________ (_____) ___________________________
First Choice Name Area Code Phone

_____________________________________ (_____) ___________________________
Second Choice Name Area Code Phone

In a medical emergency, I consent to the local/state advisor or appointed agent, his, her or their discretion in using, taking, arranging for or consenting to the procedures or treatment.

I agree to indemnify and hold harmless the ___________________ Family, Career and Community Leaders of America, the individual members, agents, employees and representatives thereof, for any and all claims, demands, actions, rights of action, and/or judgments by or on behalf of the above named member arising from or on account of said procedures and/or treatment rendered in good faith and according to accepted medical standards.

I assume the total financial responsibility for the above named member and will not hold the _________________ Family, Career and Community Leaders of America responsible in the event of a medical emergency.

____ ____
Signature of Parent/Guardian Date

____
Social Security Number of Parent/Guardian (optional)

It is the policy of the Missouri Department of Elementary and Secondary Education not to discriminate on the basis of race, color, religion, gender, national origin, age, or disability in its programs or employment practices as required by Title VI and VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Title II of the Americans with Disabilities Act of 1990. Inquiries related to Department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Office of the General Counsel, Coordinator–Civil Rights Compliance (Title VI/Title IX/504/ADA/Age Act), 6th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number (573) 526-4757 or TTY (800) 735-2966, fax (573) 522-4883, email civilrights@dese.mo.gov.