Pennsylvania Association of Student Councils State Conference Delegate

MEDICAL PERMISSION SLIP

This form MUST be completed, signed, and mailed with the PASC State Conference registration. No student will be allowed to attend a PASC State Conference without submitting this information.

Name:_____Age:_____Gender:_____
First Middle Last

Complete mailing address: _____
Number & Street City State Zip

Home Phone: (____)_____ Parent Name(s): _____

Parent Work/Cell Phones: (____)_____[w] (____)_____[c]

Student Date of Birth _____/_____/_____

Alternate Emergency Contact: Name, address, phone of person to be contacted if parent cannot be reached

_____

_____

Specific Allergies:_____

Medical Conditions: _____

Medications: _____

Date of last tetanus shot: _____/_____/_____ Tylenol Allowed: ___Yes ___No Advil Allowed: ___Yes ___ No

Should the delegate be restricted from any type of recreational activity? ___Yes ___No

If yes, explain:_____

Are there any prescription or non-prescription drugs that should NOT be administered?

If yes, list:_____

Medical Insurance Company Name:_____

Address: _____
Number & Street City State Zip

Policy Number: _____ Phone Number:(____)_____

Physician Name: _____ Phone Number: (____)_____

Signature of Person Holding Insurance _____ _____

NOTE: If you are taking medication regularly, please bring a supply in a labeled container.

I, the parent or legal guardian of _____ (my child) authorize the Pennsylvania Association of Student Councils to obtain medical care for my child in the event such care is necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a licensed physician or accredited hospital permission to perform any medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment of such care. I release PASC, its staff, and agents from any damages, liability, or loss resulting from their securing in good faith medical care for my child. I further acknowledge and understand that I will be responsible for any medical bills that may be incurred on behalf of my son/daughter for physical illness or injury that he/she may sustain during the PASC meetings, conferences, and activities. I grant permission for my son/daughter to be transported by a PASC staff member, for medical treatment in a non-emergency situation.

Signed: _____
(Parent or Guardian) (Date)