

GUEST: \_\_\_\_\_ ADVISOR: \_\_\_\_\_ SCHOOL: \_\_\_\_\_



## Guest Participation Form

### Code of Conduct

Due to legal restrictions, it is necessary that all guests complete this form to be eligible to attend any North Carolina HOSA event. This form should be returned to the HOSA Chapter Advisor who will make a copy for his/her records and forward all forms to North Carolina HOSA. Please make sure this form is turned in by the appropriate conference deadline.

A good reputation enables you to take pride in your organization. HOSA members and advisors have an excellent reputation of standards to uphold. As a guest, your conduct at any HOSA function should enhance the reputation that has been established.

1. Behave in a courteous and respectful manner, refraining from language and actions that might bring discredit upon themselves, their school, other delegates, advisors, or upon HOSA.
2. Obey all local, state, and federal laws.
3. HOSA name badge and proper attire must be worn at all times.
4. Guests are to report any accidents, injuries, or illnesses to their local advisor immediately.
5. If a guest is responsible for stealing, vandalism, or improper behavior, the guest will be expected to pay any and all damages. Violators will be removed from the conference at their expense.
6. Guests may NOT use or have in their possession any drugs, alcohol, vape or tobacco products at any time. Violators will be removed from the conference at their expense.
7. No guests/students of opposite sex allowed in hotel room together without chaperone approval and if chaperone approval, the door must be open.
8. Observe the curfew hour of events as listed in the conference program and keep local advisor informed of activities and whereabouts at all times.

I have read the above Code of Conduct for HOSA activities and agree to abide by these rules established by North Carolina HOSA. I understand that if the guest disregards these rules, they will be subject to disciplinary action and may be sent home at their own expense.

### Photo Release

By attending this event, the guest consents to North Carolina HOSA taking photo/video of the guest during the event. North Carolina HOSA is authorized to use and publish these photos/videos in print and/or electronically and may use these photos/videos for any lawful purpose, including for example: publicity, illustration, advertising, and Web content.

GUEST: \_\_\_\_\_ ADVISOR: \_\_\_\_\_ SCHOOL: \_\_\_\_\_



## Guest Participation Form

### Medical Liability Release

**DIRECTIONS:** Due to legal restrictions, it is necessary that **all** conference attendees complete this form to be eligible to attend any HOSA Leadership Conferences. This form should be returned to the HOSA Chapter Advisor who will forward a copy of the form to NC HOSA. The original forms must be maintained by the local advisor and travel with the advisor. Please TYPE or PRINT all information. Check conferences you may be attending. There is a separate form for the International Leadership Conference.

HOSA Activity:

NC HOSA Fall Leadership Conference 2023  NC HOSA Regional Leadership Conference 2023  NC HOSA State Leadership Conference 2024

Participant's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Home Address \_\_\_\_\_

Parent/Guardian Name (for guests under age 18) \_\_\_\_\_

Parent/Guardian: Home#: \_\_\_\_\_ Work#: \_\_\_\_\_

Alternate/Emergency Contact: \_\_\_\_\_

Telephone #: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Are you covered by group or medical insurance?  Yes  No If yes, name of insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies or reactions to any medications: \_\_\_\_\_

Physical handicaps: \_\_\_\_\_

Convulsions/Seizures:  Yes  No; Blackouts/Fainting:  Yes  No; Heart or Lung problems:  Yes  No

If yes, describe: \_\_\_\_\_

Diseases/Illness: \_\_\_\_\_

Other: \_\_\_\_\_

If currently taking medication, please provide the following information:

a. Name/Dosage of Medication(s) \_\_\_\_\_

b. Prescribing Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

**GUEST/(PARENT/GUARDIAN if UNDER AGE 18):** Please check one of the following and sign your name.

I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.

I do not give permission for medical treatment until I have been contacted.

