

WASHINGTON STATE FUTURE BUSINESS LEADERS OF AMERICA EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Name of Student _____

Home Address _____ Phone _____

_____ Date of Birth _____

Name of School _____

Name of Activity and Location _____

Date(s) of Activity _____

Adviser/Chaperone _____

This is to certify that _____ has my permission to attend the above-named FBLA activity. I have read the FBLA Code of Conduct and am in agreement with that Code and its consequences. I also hereby absolve and release Washington State FBLA from any claims for personal injuries which might be sustained by the above-named student while he/she is enroute to or from any FBLA-sponsored activity.

AND

In the event of accident or illness, I authorize the above adviser/chaperone or State FBLA staff to secure services of medical personnel and/or hospital if necessary. I accept responsibility for payment of these expenses.

Parent/Guardian Signature _____ Phone _____

Date _____

Alternate Contact Person _____ Phone _____

MEDICAL INFORMATION

Known allergies (drug and natural) _____

Medication(s) taken _____

Current or pre-existing physical or medical restriction/conditions _____

History of heart condition, diabetes, asthma, epilepsy, rheumatic fever or other (please specify)

Date of last tetanus shot _____

Family Doctor _____ Phone _____

INSURANCE INFORMATION

Insurance Company _____

Policy/Group Number _____