



# NEBRASKA FBLA MEDICAL RELEASE FORM

CHAPTER \_\_\_\_\_

I, \_\_\_\_\_ of \_\_\_\_\_ am the \_\_\_\_\_ of  
Parent/Guardian Address City, State, Zip Relationship

Member's date of birth \_\_\_\_\_  
Member's, Adviser's or Guest's Name

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 from \_\_\_\_\_ to \_\_\_\_\_

Student

**Parent/Guardian  
Phone Numbers**

Parent/Guardian Name \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_  
Work \_\_\_\_\_ Work \_\_\_\_\_  
Home/Cell \_\_\_\_\_ Home/Cell \_\_\_\_\_

**Physician** \_\_\_\_\_

**Dentist** \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Medical insurance company \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of insured \_\_\_\_\_

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

Allergies \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

Medication being taken \_\_\_\_\_

Physical impairments \_\_\_\_\_

Other pertinent facts to which a physician should be alerted. \_\_\_\_\_

**If Parent/Guardian cannot be reached in case of emergency call:**

First Choice Name \_\_\_\_\_ (Area code) Phone Number \_\_\_\_\_

Second Choice Name \_\_\_\_\_ (Area code) Phone Number \_\_\_\_\_

In a medical emergency, I consent to the local/state adviser(s) or appointed agents, 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 Nebraska Association of Future Business Leaders of America, to indemnify members, agents, employees and representatives thereof, for any and all claims, 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 Nebraska Association of FBLA responsible in the event of a medical emergency.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_