NEBRASKA FBLA MEDICAL RELEASE FORM

CHAPTER _____

I, _____ (Parent/Guardian) of _____ (Address, City, State, Zip) am the _____ (Relationship) of _____ (Member's, Adviser's or Guest's Name). Member's date of birth _____

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 _____ (Student) is absent from home from _____ to _____.

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