SkillsUSA®

District 2 CTSO Fall Leadership Conference

REGISTRATION, PERSONAL AND LIABILITY RELEASE FORM

Read the other side of this form. Then, complete the *entire* form. Type or print clearly. You must wear your name badge *at all times* during the conference.

1 Complete this entire section.

Participant's home address is required. Do not use school address as home address.

SkillsUSA State Association: Pennsylvania	Parents'/Guardians' Names (if participant is under age 18):
Check one: X High School Division (Secondary) / College/Postsecondary Division	Parents' Telephone Number (area code required): ( )
Participant's Name (First, Last) as it should appear on name badge:	Name of Teacher/Adult accompanying participant to conference, if applicable:
Participant's HOME Address:	Name of SkillsUSA Advisor for participant's occupational area:
City: / State: / ZIP Code:	School where participant's occupational training/trade area is taught:
HOME Telephone (area code required): ( ) / CELL Phone (area code required): ( )	Mailing Address of above school:
Age: / Date of Birth (MM/DD/YY): / Check one: Male / Female	City: / State: / ZIP Code:
E-MAIL address:	School Telephone Number (area code required): ( )

2 Please check one.

Check one:

☐ Student

☐ Advisor

I hereby grant permission for my son/daughter to attend the LEADERSHIP CONFERENCE at POCONO MANOR, November 14, 15, 16, 2018. In the event he/she does not attend I will pay an additional $375 to reimburse the school for costs already incurred.

Parent/Guardian Signature

_____

3 Medical and Insurance Information. Complete this entire section.

Participants should carry a copy of their insurance card at all times during the conference.

If the participant doesn't have insurance, check where noted.

Name of Person to Contact in Event of Emergency:	Name of Person Responsible for Participant's Medical Bills:
Contact Person's HOME Telephone Number (area code required): ( )	Participant's Relationship to Person Responsible for Medical Bills (example: son, daughter):
Contact Person's WORK Telephone Number (area code required): ( )	Participant: Do you have a history of (check all that apply):
Contact Person's CELL Telephone Number (area code required): ( )	Allergies? No Yes Heart condition? No Yes Diabetes? No Yes Asthma? No Yes Epilepsy? No Yes Rheumatic fever? No Yes Other existing medical conditions? No Yes If "yes," please explain:
Name of Family Physician: Physician's Telephone Number: ( )	
Name of Insurance Company:	
Name of Insured:	
Insured's Plan Number:	Participant: Are you taking medication? ☐ No ☐ Yes
Insured's Group Number:	If "yes," please attach description on separate sheet.
Insurance Company's Telephone Number for Member Services: ( )	Participant: When did you last have a tetanus shot?
Insurance Company's Telephone Number for Precertification: ( )	Check "yes" if participant has a disability that meets criteria specified in the Americans with Disabilities Act (ADA). We will contact you for further information. ☐ Yes
If participant does not have any medical insurance, check here: ☐	

4 Check the appropriate box to signify the participant's agreement.

I have read and completely understand the Personal Liability and Medical Release Form, the Code of Conduct, the Release of Personal Information Through Lead Retrieval System statement, and the Photography and Sound Release agreement, and, by checking the box, do hereby agree to abide by these in their entirety, accept the conditions of the agreements, and completely release SkillsUSA's national and state associations.

THIS COMPLETED FORM MUST BE TURNED IN OR PARTICIPANT WILL NOT BE ALLOWED TO ATTEND.