

\*\*A SEPARATE FORM IS REQUIRED FOR **EACH STUDENT** ATTENDING STATE AUTHORIZED ACTIVITIES. Duplicate as necessary.

**AUTHORIZATION - MEDICAL RELEASE - PARENTAL CONSENT FORM**

Student Name \_\_\_\_\_

Name of Organization \_\_\_\_\_

Adviser \_\_\_\_\_ School Name \_\_\_\_\_

**ADVISER AUTHORIZATION AND STUDENT PARTICIPATION AT ALL LOCAL, DISTRICT, STATE, AND NATIONAL VSO ACTIVITIES FOR THE YEAR DESIGNATED BELOW:**

Date(s) of Activity: From August 1, 20 to July 31, 20

I, the adviser, hereby certify that this student has been authorized to represent our chapter as a participant/delegate and has received instructions concerning the organization rules at state authorized activities.

\_\_\_\_\_  
(Signature of Adviser) (Date)

I, the student, do hereby verify that I have received the above information.

\_\_\_\_\_  
(Signature of Student) (Date)

**MEDICAL RELEASE:**

I, \_\_\_\_\_  
(Parent's/Guardian's Signature)

\_\_\_\_\_ of \_\_\_\_\_  
(Relationship) (Student's Name)

\_\_\_\_\_ of \_\_\_\_\_  
(Date of Birth) (Complete home address including ZIP Code)

hereby authorize in advance any necessary medical treatment required for my son/ daughter. This student is presently under medical care.  Yes  No

If yes, explain: \_\_\_\_\_

Date Signed \_\_\_\_\_ Parent/Guardian Home Phone \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Insured \_\_\_\_\_

Name of Family Physician \_\_\_\_\_

Any allergies, medications, etc. \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION:** I agree not to hold the Colorado Vocational Student Organizations, the State Board for Community Colleges and Occupational Education, or any of its agents, liable for any accident, illness, or injury to my son/daughter/ self during participation in any state authorized activity, including travel to and from activity sites.

\_\_\_\_\_  
(Signature of Parent/Guardian if student is under 18 years) (Date)

\_\_\_\_\_  
(Signature of student if student is over 18 years) (Date)