INDIANA FFA CAREER DEVELOPMENT EVENT

PARENT CONSENT, MEDICAL RELEASE FORM AND AGREEMENT TO ACCEPT FINANCIAL RESPONSIBILITY

I grant permission for my son/daughter (name) _____ to participate in the State FFA Activity listed above. In doing so, I release the school corporation, school personnel, Indiana FFA Association, host facility and staff, state FFA staff and contest officials and the FFA of all responsibility in the event of an injury or accident. It is agreed that the student will conduct himself/herself in a manner representative of the school, community and the FFA. Any illegal substance or unlawful behavior will be turned over to the proper local authorities.

The undersigned, being parent/guardian of (name) _____ and having legal custody and who resides with me, does give consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the United States of America, and to consent to any X-ray, examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care to be rendered to the minor by any dentist licensed to practice in the United States of America.

I/We further agree that I/we will assume all expenses involved in such medical/dental procedures and will not hold the school corporation, school personnel or the FFA liable for said expenses.

I/We further agree that any photos or video taken of my child can be used by the Indiana FFA for official purposes in publications such as but not limited to the FFA website, conference brochures and information given to FFA sponsors.

Student _____ Date _____

Parent/Guardian _____ Date _____

Parent/Guardian _____ Date _____

Address _____ City/State/Zip _____

Emergency contact number: _____ Home or cell # _____

Please list any medical/dental conditions of which a medical doctor/dentist should be made aware:

Please list any allergies of which a medical doctor/dentist should be made aware:

Please list any medication(s) – prescription or other which are currently being taken:

Family Physician _____

Address _____Phone _____

PLEASE FEEL FREE TO DUPLICATE.

SEND COMPLETED FORM TO CONTEST FOR EACH CONTESTANT WITH REGISTRATION.