 **Mississippi**

**2023 - 2024**

**SkillsUSA - Mississippi**

**Personal Liability / Medical Release / Photograph Release**

All children, students, and adults who attend any **Mississippi SkillsUSA Regional** **or** **State Conference** are required to fill out this form. No conference attendee will be allowed to participate unless Mississippi SkillsUSA receives this form. Parents and chapter advisor: **Please make a copy of this completed form for your records**.

Student: \_\_\_ Student cell: Student date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: Cell Phone: Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Advisor: School: School phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School address City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL and INSURANCE INFORMATION** (students only)

Physician’s Name: Work #: Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relative’s Name: Work#: Home#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies (drug or otherwise)

Current medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe any history of heart condition, diabetes, asthma, epilepsy, or rheumatic fever, etc. AND/OR Physical Restrictions (swimming, running, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Insurance Information**

Medical Insurance Co.: Identification/Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name: Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s place of employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PLEASE INITIAL EACH STATEMENT WITH WHICH YOU AGREE.***

**Initials \_** “I hereby agree to release the Mississippi SkillsUSA, its representatives, agents, servants and employees from liability for any injury to above named person at any time while attending the Mississippi SkillsUSA Activity, including travel to and from the conference, excepting only such injury or damage resulting from willful acts of such representatives, agents, servants, and employees.”

**Initials \_** “I do voluntarily authorize the Mississippi SkillsUSA local chapter advisors, state advisor, assistants and/or designees to administer and/or obtain routine or emergency medical treatment for the above-­‐named person as deemed necessary in medical judgment.”

**Initials \_** “I agree to indemnify and hold harmless the Mississippi SkillsUSA and/or assistants and designees for any and all claims, demands, actions, rights of action, or judgments by or on behalf of the above-named person arising from or on account of said procedures or treatment rendered in good faith and according to accepted medical standards.”

**Initials \_** “I hereby authorize any physician member of the Department of Emergency Medicine of an accredited hospital or any member of the medical staff of an accredited hospital to render medical treatment, which in his/her judgment is deemed necessary in the care of the above-named person (child or student) while attending the Mississippi SkillsUSA Activity, including time traveling to and from the conference.”

**Initials \_** “I permit Mississippi SkillsUSA to use video footage and photographs of my child for publicity that might include but is not limited to website, PowerPoint presentations, promotional videos, flyers or news publications.”

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Signature of parent or guardian (if child or student) Date

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Participant's signature Date

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Advisor’s signature Date

**A COPY OF THIS FORM MUST BE KEPT BY THE STATE AND CHAPTER ADVISORS AT THE CONFERENCE AND GIVEN TO APPROPRIATE MEDICAL AUTHORITIES IN THE EVENT OF A MEDICAL EMERGENCY.**

**This form is valid from September 1, 2023, until May 30, 2024**