

Dues: \$20



Fall Leadership Conference September 29 - October 1, 2011 Registration, Personal and Liability Release Form

Local Chapter: <u>Summit Technology</u>	Parents' Names
Check one: <input checked="" type="radio"/> Secondary Division <input type="radio"/> Postsecondary Division	Parents' Telephone Number (area code required)
Participates Name (First, Last) as it should appear on name badge:	Name of Teacher accompanying participate <u>Eric Walters, Lisa Oylar</u>
Participant's Home Address:	School: <u>Summit Technology</u>
City: _____ State: _____ Zip Code: _____	Mailing address of school: <u>777 NW Blue Pkwy</u>
Home Telephone Number (area code required) () -	City: <u>Lees Summit</u> State: <u>MO</u> Zip Code: <u>64081</u>
Age: _____ Date of Birth: _____ Circle one: <input type="radio"/> Male <input type="radio"/> Female	School telephone Number (area code required): <u>(816) 986-3410</u>
Circle one: <input type="radio"/> Participant <input type="radio"/> Advisor <input type="radio"/> Administrator <input type="radio"/> Other	Occupational Training Area:

Emergency & Medical Information

Photocopy your insurance card and attach the copy to this form.

Name of Person to Contact in event of emergency:	Name of person responsible for Participants Medical Bills:
Contact Person's home phone Number (area code required): () -	Participant's Relationship to Person responsible for Medical Bills
Contact Person's work phone (with area code): () -	Participant: Do you have a history of Allergies? Circle one <input type="radio"/> No <input type="radio"/> Yes
Name of Family Physician:	Participant: Do you have a history of a Heart Condition: circle one <input type="radio"/> No <input type="radio"/> Yes
Physician's phone number:	Participant: Do you have a history of Diabetes? <input type="radio"/> No <input type="radio"/> Yes
Name of Insurance Company:	Participant: Do you have a history of Asthma? <input type="radio"/> No <input type="radio"/> Yes
Name of Insurer:	Participant: Do you have a history of Epilepsy? <input type="radio"/> No <input type="radio"/> Yes
Insured's Plan Number:	Participant: Do you have a history of Rheumatic Fever? <input type="radio"/> No <input type="radio"/> Yes
Insured's Group Number:	Participant: Do you have other existing condition? <input type="radio"/> No <input type="radio"/> Yes
Insurance Company's phone Number for Member Services: () -	If yes, please explain:
Insurance Company's phone Number for Precertification: () -	If taking medication please provide description:
Does Participant have health Insurance: circle <input type="radio"/> NO <input type="radio"/> Yes	Participant: when did you last have a tetanus shot: Date
Circle yes if participant has a disability that meets criteria specified in the Americans with Disabilities Act (ADA)	<input type="radio"/> Yes

I have read and completely understand the Personal Liability and Medical Release Form, the Code of Conduct, and the Photography and Sound Release agreements, and by signing, do hereby agree to abide by these in their entirety, accept the conditions of the agreements, and completely release SkillsUSA's national, state and district associations.

Participant's Signature

Parent/Guardian Signature if under age 18