# Delaware Department of Education LogoSTUDENT PERMISSION/

**Medical Emergency Treatment**

**PARENT OR GUARDIAN PERMISSION**

has my permission to attend and participate in the following activities:

* 2023 State Officer Leadership Training
  + Wilmington University – Dover Campus
  + June 14-15, 2023

I understand my student will be traveling by **student/family car for the event(s).** My student has been made aware that they are to obey the rules of the Delaware delegation and of the supervisors assigned to them. If there is some reason my child needs medical attention or for some disciplinary reasons must be sent home, I will be contacted. **This completed form should be returned to your State Advisor or designee by June 9, 2023.**

Signature of Parent or Guardian Date

## \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* Medical Data

Please Print -- List any **food allergies**, allergies, illnesses, and/or medical conditions for which medicine, treatment, and/or other accommodations may be needed during the conference period\*\*

**Food allergies**, allergies, illnesses, and/or medical conditions:

Type of Medicine carried:

Currently being treated for:

Name and address of family physician:

Physician’s phone:

Name and address of person to contact in case of illness:

Contact person’s phone:

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**Medical Emergency Treatment**

I, (Parent/Guardian's Name) (Relationship)

of (Name of Participant) (Age)

## Complete Home Address: (including Zip)

**(Area code and Home telephone No.)**

## (Area code and Work telephone No.)

I hereby authorize in advance the advisor/CTSO representative to secure the services of a physician or hospital, and to incur the expenses for necessary services in the event of accident or illness, and I will provide for the payment of these costs.

I also do hereby on behalf of him/her absolve and release the school officials, the CTSO chapter advisors and the assigned state/provincial CTSO staff from any claims for personal injuries or illness which might be sustained while he/she is en route to and from or during any DE CTSO sponsored activity.

Medical/hospitalization carrier policy number:

Other Medical Insurance:

Policy Number:

I also agree that the school officials, the CTSO chapter advisors, the state/provincial CTSO staff, or the Conference Conduct Committee members have the right to send my child home from the activity at our expense, provided that he/she has violated the Code of Conduct and/or his/her conduct has become a detriment.

(Parent/Guardian’s Signature)

# Delaware Department of Education LogoParental Authorization Photo Release Form

**Please check one:**

I hereby grant the Delaware Department of Education permission to use

’s (please insert student’s FULL name) picture for publication purposes only.

*I release and indemnify the Delaware Department of Education from and against any claims or causes of action that I or my child may have against the Department of Education, invasion of my child’s right of privacy, or any other manner in any way connected with the use or publication of the photographs taken by the Department of Education.*

**I do not** wish to grant permission to the Delaware Department of Education to use my child’s picture for publication.

Parent/Guardian’s signature Date

Parent/Guardian’s printed name and relationship to above

If in high school, signature of student Date

Student’s printed name