

SKILLSUSA National Leadership and Skills Conference REGISTRATION, PERSONAL AND LIABILITY RELEASE FORM

Read the other side of this form. Then, complete the entire form. Type or print clearly. You must wear your name badge *at all times* during the conference.

1 Complete this entire section.

State SkillsUSA Association: Massachusetts			Parents'/Guardians' Names (if participant is under age 18):		
Check one: <input type="checkbox"/> High School Division (Secondary) <input type="checkbox"/> College/Postsecondary Division			Parents' Telephone Number (area code required): ()		
Participant's Name (First, Last) as it is to appear on name badge:			Name of Teacher/Adult accompanying participant to conference, if applicable):		
Participant's Home Address:			Name of SkillsUSA Advisor for participants' occupational area:		
City:	State:	ZIP Code:	School where participant's occupational training/trade area is taught:		
Home Telephone (area code required): ()		Cell Phone (area code required): ()		Mailing Address of above school:	
Age:	Date of Birth (month/day/year):	Check one: <input type="checkbox"/> Male <input type="checkbox"/> Female		City:	State:
E-mail address:			School Telephone Number (please include area code):		

2 Contestants and models only, complete this section. Check if officer candidate. All others, complete this section. NTHS? Check:

Check one: <input type="checkbox"/> Contestant <input type="checkbox"/> Nail Care Model		Contest abbreviation: _____ and Name (from cover sheet) in which competing:	
<input type="checkbox"/> Auto Service Technology Contestant (Fee waived ONLY if competing at national conference. Does not apply to state conferences.)		Occupational training/trade area in which contestant is enrolled:	
<input type="checkbox"/> National Officer Candidate			
Check one: <input type="checkbox"/> Advisor (Teacher) <input type="checkbox"/> Auto Service Technology Contestant's Advisor (Fee waived ONLY if your student is competing at national to state conferences.)		<input type="checkbox"/> State Association Director	
<input type="checkbox"/> Delegate		<input type="checkbox"/> State Association Director's Spouse/Child	
<input type="checkbox"/> National Technical Honor Society: Student Member		<input type="checkbox"/> National Technical Honor Society: Advisor	
<input type="checkbox"/> Observer/Other _____			

3 Medical and Insurance Information. Complete this entire section.

Participants should carry a copy of their insurance card at all times during the conference.

If the participant doesn't have insurance, check were noted.

Name of Person to Contact in event of emergency:		Name of Person Responsible for Participant's Medical Bills:	
Contact Person's HOME Telephone Number (area code required): ()		Participant's Relationship to Person Responsible for Medical Bills (example: son, daughter):	
Contact Person's WORK Telephone Number (area code required): ()		Participant: Do you have a history of (check all that apply): Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes Heart condition? <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes Asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy? <input type="checkbox"/> No <input type="checkbox"/> Yes Rheumatic Fever? <input type="checkbox"/> No <input type="checkbox"/> Yes Other existing medical conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes If "yes", please explain: _____	
Contact Person's CELL Telephone Number (area code required):			
Name of Family Physician: Physician's Telephone Number: ()			
Name of Insurance Company:			
Name of Insured:		Are you taking medication? If "yes," please list what kind: _____	
Insured's Plan Number:		Participant: Are you taking medication? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Insured's Group Number:		If "yes," please attach description on separate sheet.	
Insurance Company's Telephone Number for Member Services: ()		Participant: When did you last have a tetanus shot?	
Insurance Company's Telephone Number for Precertification: ()		Check "yes" if participant has a disability that meets criteria specified in the Americans with Disabilities Act (ADA). We will contact you for further information. <input type="checkbox"/> YES	
If participant does not have any medical insurance, check here: <input type="checkbox"/>			

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

PARTICIPANTS—
CHECK HERE IF YOU ARE OVER 18 AND CAN SIGN FOR YOURSELF:

PARENT/GUARDIAN - CHECK HERE TO ATTEST FOR PARTICIPANT:
(MANDATORY IF PARTICIPANT IS UNDER AGE 18)

Signature of Participant

Date

Signature of Parent or Guardian (Mandatory if under age 18.)

Date

THIS COMPLETED FORM MUST BE TURNED IN, OR PARTICIPANT WILL NOT BE ALLOWED TO ATTEND.