

The Advisor's Code of Conduct is made available by the HOSA, Inc. Board of Directors for distribution by states on an as-needed basis. Whether there is a signed agreement or not, these are the standards expected of all advisors and guests attending any HOSA function.

## ADVISOR/CHAPERONE CODE OF ETHICS

1. HOSA Advisors project a positive and professional image of Health Occupations Education and HOSA to all those with whom they interact.
2. HOSA Advisors promote HOSA as a positive student experience; therefore, they will act as a positive role model for students in dress, voice, attitude, actions, and demeanor.
3. HOSA Advisors are accountable to and for their students in all HOSA-related activities.
4. HOSA Advisors understand and follow established processes within the organization that protect the rights of all members.

HOSA Advisors are proud of the standard of excellence they maintain for themselves and their students. Attendance at any HOSA function implies acceptance and practice of these standards.

**I have read the above Code of Ethics for HOSA Advisors/Chaperones and agree to accept and practice these standards.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

# HOSA ADVISOR/CHAPERONE MEDICAL LIABILITY RELEASE FORM

**DIRECTIONS:** Due to legal restrictions, it is necessary that all HOSA Advisors/Chaperones complete this form as a prerequisite to attend National or State conferences and functions. This form should be returned to the State Advisor.

## PLEASE TYPE OR PRINT ALL INFORMATION

Advisor's Name \_\_\_\_\_

Advisor's Address \_\_\_\_\_

Advisor's Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Name of Physician \_\_\_\_\_ Physician's Telephone \_\_\_\_\_

Alternate Contact Person \_\_\_\_\_ Home phone \_\_\_\_\_ Work \_\_\_\_\_

School Name \_\_\_\_\_ School Phone \_\_\_\_\_

Advisor is covered by group or medical insurance:  Yes  No

If yes, complete the following information.

Name of Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Please completely describe any medical condition which may recur or be a factor in medical treatment. Use additional piece of paper if necessary.

- |                                 |                                     |
|---------------------------------|-------------------------------------|
| A. Disease of Any Kind _____    | E. Convulsions _____                |
| B. Physical Handicap _____      | F. Blackouts _____                  |
| C. Medicine Reactions _____     | G. Allergy _____                    |
| D. Heart or Lung Problems _____ | H. Other (please be specific) _____ |

If currently taking medication, please provide the following information:

A. Name of Medication \_\_\_\_\_

B. Prescribing Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Please check one of the following and sign your name.

- A. I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify any persons listed above as soon as possible.
- B. I do not give permission for medical treatment until Alternate Contact Person has been contacted.

ADVISOR'S SIGNATURE \_\_\_\_\_

**LIABILITY RELEASE.** I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his or her own insurance coverage during this trip. I hereby release the National and Florida HOSA Board of Directors, the National and State Staff, State and Local HOSA Associations, and any designated individual in charge of the HOSA group or specific activity from any legal or financial responsibility with respect to my personal or my student's/child's participation in or contact with any known element associated with any activity including competitive events.

\_\_\_\_\_  
Advisor's/ Chaperone's Signature

\_\_\_\_\_  
Date