



MEDICAL CONSENT FORM

Family, Career and Community Leaders of America, Inc.

13241 Woodland Park Rd, STE 100,

Herndon, VA 20171

All Baking and Pastry and Culinary Arts STAR participants must return this completed consent form to the National Office by June 15. All medical information must be complete and accurate. Failure to do so may result in disqualification.

_____ has permission to receive medical treatment by a physician should an illness or minor accident occur while participating in the Baking and Pastry or Culinary Arts STAR Event with the national Family, Career and Community Leaders of America, Inc. The following information be helpful in such a situation arises:

Our family physician is: _____ Phone (____) _____

Physician's address: _____

Known allergies: _____

Special medical conditions that should be noted: _____

Prescription number and pharmacy for special medication currently taken: _____

Contact in case of emergency: _____

Comments: _____

Insurance Company: _____

Identification #: _____

Group #: _____

Location of Card: _____

Insurance Company Phone Number: (____) _____

I have read and consent to the above.

(Signature of Parent/Guardian) (Date)

(Signature of Participant) (Date)