

**Convention  
March 11-13  
2025**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Region: \_\_\_\_\_ School \_\_\_\_\_

**ADULT EMERGENCY INFORMATION FORM**



*Cell Phone	Emergency Contact:	Emergency Contact Cell:	
Who is responsible for medical payments? <input type="checkbox"/> Individual <input type="checkbox"/> Insurance	School Insurance? Day: <input type="checkbox"/> Yes <input type="checkbox"/> No 24 Hour <input type="checkbox"/> Yes <input type="checkbox"/> No	School Insurance: Company Name:	
Private Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Private Medical Insurance Company Name:	Policy Number:	
Date of last Immunization Booster:	ALLERGIES: <input type="checkbox"/> Bee Sting <input type="checkbox"/> Poison Oak/Ivy <input type="checkbox"/> Ragweed <input type="checkbox"/> Penicillin <input type="checkbox"/> Other (Describe): Are you allergic to any medication? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list:		
<b>Special Dietary Considerations</b>	<b>MASC may provide me with:</b> <input type="checkbox"/> Tylenol <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Benadryl		
BRIEF MEDICAL HISTORY (Special Health Conditions – diabetes, seizures, etc.)			
<b>NOTE: The on-site nurse is available to handle on-site urgent care only during convention times at the Convention Center -the nurse is not available at the hotels</b>			
Describe any activity in which participant may <u>NOT</u> participate:			
<b>PERMISSION</b>			
I, _____ authorize the MASC executive director or his/her designee to obtain medical care for me in the event such care is necessary. I understand that, if possible, my emergency contact will be notified. I grant to a licensed health care provider or accredited hospital, permission to perform any medical and/or surgical procedures that are essential for the treatment of myself, and agree to be responsible for payment of such care. I release MASC, its employees, and agents from any damages, liability, or loss resulting from their securing, in good faith, medical care for my child.			
<b>*PHOTO PERMISSION</b> (names will NOT be used if requested)			
Photographs of me <input type="checkbox"/> MAY <input type="checkbox"/> MAY NOT be posted on or used by MASC or other student leadership websites.			
<b>Advisor Signature:</b> _____		<b>Date:</b> _____	
<b>DO NOT E-MAIL THIS FORM</b> - it will be submitted at the on-site check-in			

*This confidential form will be shredded after the conference*

**Advisors should make a copy of this form to have at the hotel at night.** Your region might want to designate an advisor to keep all of the advisor forms for emergencies at night in the hotel.