Please email or fax ----------------------------------->

Return form to:
Mr. Bruce E. Boncal
PA FBLA Executive Director
Deadline: October 14, 2016

Each chapter's forms must be made into a single PDF file and emailed to bboncal@pafbla.us OR faxed to 570.398.4652.

FUTURE BUSINESS LEADERS OF AMERICA
Adviser/Guest/Chaperone Emergency Form

Please Note: It is the responsibility of the local chapter adviser to submit an emergency form for each adviser/guest/chaperone attending the PA FBLA State Leadership Workshop. The form must be uploaded to the **PA FBLA Executive Director** RECEIVED BY **October 14, 2016**. If an adviser fails to submit the emergency form(s) by the deadline, the adviser and the school's principal may be notified that the chapter will not be able to attend the PA FBLA State Leadership Workshop.

This form is submitted by ______________________________ , who is attending
name

the **PA FBLA State Leadership Workshop** held at the **Harrisburg Hilton**
activity **location**

Harrisburg, Pennsylvania on **November 6-7, 2016 (November 5 optional)**.
location **dates**

Participant's Home Street Address ______________________________

Participant's Home City/State/Zip ______________________________

Home Telephone Number ______________________________ Date of Birth ______________

School Name ______________________________

EMERGENCY INFORMATION

The information on this form will be kept confidential and will only be provided to emergency services/ medical personnel if necessary.

I/we authorize the emergency management/medical staff or other responsible adult to take the above-named adviser/guest/ chaperone to a physician or emergency room of a hospital and to incur expenses for necessary services and realize payments of these costs is my/our responsibility.

Name of Emergency Contact Person ______________________________

Home Telephone Number ______________________ Work Telephone Number ______________________

Family Physician Name ______________________________ Physician Phone Number ______________

You may voluntarily provide this information, if you wish, to share with emergency medical personnel/first responders.

List Medications the Adviser Is Taking ______________________________

List Any Other Medical Requirements ______________________________

Insurance Company Name______________________________ Plan Number/Group Number ______________

Insurance Policy Number ______________________________

____
Adviser/Guest/Chaperone Signature **Date**