FCCLA
NORTH CAROLINA

MEDICAL CONSENT FORM

All Baking & Pastry and Culinary Arts STAR Event participants must submit this completed consent form during check-in at the Culinary Competition. 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 accident occur while participating in the Baking & Pastry or Culinary Arts STAR Event with the North Carolina Family, Career and Community Leaders of America. The following information will be helpful if such a situation arises.

Primary Physician Name: _____
Physician's Address: _____
Physician's Phone Number: _____

Known Allergies: _____

Medical condition(s) that should be noted:

_____

_____

Medications currently being taken (OTC or prescribed):

_____

_____

EMERGENCY CONTACT INFORMATION

Name: _____
Phone #: _____ Relationship to Participant: _____

INSURANCE INFORMATION

Insurance Company Name: _____ Phone #: _____
ID #: _____ Group #: _____

I have read and consent to the above statement. I acknowledge that all the information provided is accurate.

Parent/Guardian First and Last Name: _____
Parent/Guardian Signature: _____

Participant First and Last Name: _____
Participant Signature: _____