MEDICAL INFORMATION/RELEASE FORM

Odyssey of the Mind

NOTE: This completed and signed form is required for all participants and due at registration.

Membership Name: _____

Membership #: _____ **Problem #:** _____ **Division #:** _____

Coach's Name:_____ **Coach's Cell #:** _____

State, if USA or Country, if not USA: _____

Student's Name: _____ ☐ **Female** ☐ **Male**

Date of Birth: Month_____ **Day**_____**Year**_____ **Age:**_____

Home Address:

_____
Number and Street

_____
City State Zip Country(if not USA)

Parent/Guardian I Information:

Name: _____ Phone #s: Home: ( )_____
Work ( )_____ Cell ( )_____
Email address_____

Parent/Guardian II Information:

Name: _____ Phone #s: Home: ( )_____
Work ( )_____ Cell ( )_____
Email address_____

Family Physician Name: _____Phone #: ( )_____

<u>Insurance Information</u> - Primary

Policy Holder's Name _____
Policy Holder's Date of Birth_____ Relationship to participant_____
Insurance Company Name_____
Policy # _____ Plan #_____
Insurance Company Phone#_____
Address_____

Secondary

Policy Holder's Name _____
Policy Holder's Date of Birth_____ Relationship to participant_____
Insurance Company Name_____
Policy # _____ Plan #_____
Insurance Company Phone#_____
Address_____

Continue on back **Over**

Medical History of Participant

List any allergies to medications, animals, foods, dust, chemicals, household items, pollen, bee stings, etc. Indicate how the allergy affects the participant.

Allergic/ Sensitive to: **Reaction:**

_____

_____

_____

_____

Date of last tetanus vaccine:_____

Is the participant under the care of a provider for a medical or psychological problem? □ Yes □ No

If yes, please explain:

Is the participant taking any medication? □ Yes □ No If yes, list medicine and purpose.

Medication **Purpose**

_____

_____

_____

_____

Please indicate any additional information you think we should be aware of:

Permission for treatment of minors: I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for the participant by the medical care facility. I understand that any healthcare facility will make every reasonable attempt to contact me first, time and conditions permitting. I understand I am responsible for charges incurred. I agree that this form will remain in the possession of the team coach, and it will accompany the student to any medical intervention.

Signature of parent or guardian of minor: _____

Relationship: _____

Printed Name: _____ Date: _____