



MEDICAL PERMISSION FORM

Odyssey of the Mind

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

Team Name: _____ Coach's Name: _____
State, if USA or Country if not USA: _____ Coach's Cell #: _____

Student's Name: _____
Female Male

Date of Birth: _____ Month: _____ Day: _____ Year: _____ Age: _____

Home Address: _____
Number & Street
City State Zip Code Country

Mother's Contact Information:
Name: _____ Phone #s: Home: () _____
Work: () _____ Cell: () _____
Email Address: _____

Father's Contact Information:
Name: _____ Phone #s: Home: () _____
Work: () _____ Cell: () _____
Email Address: _____

Other person's Contact Information: Relationship to Participant: _____
Name: _____ Phone #s: Home: () _____
Work: () _____ Cell: () _____
Email Address: _____

Family Physician Name: _____ Phone #: () _____

Insurance Information - Primary

Policy Holder's Name: _____
Policy Holder's Date of Birth: _____ Relationship to Participant: _____
Insurance Company Name: _____
Policy #: _____ Plan #: _____
Insurance Company Phone #: _____
Address: _____

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Insurance Information - Secondary

Policy Holder's Name: _____
Policy Holder's Date of Birth: _____ Relationship to Participant: _____
Insurance Company Name: _____
Policy #: _____ Plan #: _____
Insurance Company Phone #: _____
Address: _____

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 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 University Physician's Office at Michigan State University or any other medical 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 any charges incurred. I agree that this form will remain in 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: _____