

**Odyssey of the Mind 2006 World Finals
Medical Information/Release Form**

Participant Information

Last Name _____ First Name _____
Permanent Address _____ Date of Birth _____ Sex _____
City, State, Zip _____ Home Phone () _____

Event Information

Event Name and Description: _____
Event Dates (start and end dates): _____

Medical Emergency Contact Information

Person to Contact First:	Back-up Contact (Friend or Relative):
Name _____	Name _____
Relation to Participant _____	Relation to Participant _____
Daytime Phone () _____	Daytime Phone () _____
Evening Phone () _____	Evening Phone () _____

Are you allergic to any medications? _____

List current prescriptions/medications: _____

Are you currently under a doctor's care? Please explain. _____

INSURANCE POLICY INFORMATION

___ Yes ___ No The above-named participant is covered by health insurance.

If yes, provide the following information, which is required by Iowa State University to expedite treatment and to facilitate the billing process.

Policy Holder's (PH) Name _____ PH's Date of Birth _____
Address _____ Relation to Participant _____
City, State, Zip _____ Occupation _____
PH's Employers Name _____
Employer Address _____
Insurance Company Name _____
Insurance Company Address _____
Policy # _____ Plan # _____

PARENTAL PERMISSION

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter by the Iowa State University Student Health Center or any other medical facility. I understand that any health care facility will make every reasonable effort to contact me first, time and conditions permitting.

Name (Please Print) _____ Signature _____
Relationship _____ Date _____