Odyssey of the Mind 2009 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:
Name _____
Relation to Participant _____
Daytime Phone ( )_____
Evening Phone ( )_____

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