Odyssey of the Mind 2014 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 _____