# 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 and Street

______________________________________________________________________________________

City State Zip Country(if not USA)

**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 Holders Date of Birth______________ Relationship to participant________________

Insurance Company Name___________________________________________________

Policy # ___________________________________________ Plan #___________________________________

Insurance Company Phone#_________________________________

Address_____________________________________________________________________________________

**Secondary**

Policy Holder's Name ______________________________________

Policy Holders Date of Birth______________ Relationship to participant________________

Insurance Company Name___________________________________________________

Policy # ___________________________________________ Plan #___________________________________

Insurance Company Phone#_________________________________

Address_____________________________________________________________________________________

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## 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 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 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: ____________________