

**Odyssey of the Mind 2016 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 \_\_\_\_\_