MICHIGAN STATE UNIVERSITY

MEDICAL PERMISSION FORM
Odyssey of the Mind

UPhys. University Physician's Office

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 #: ( )_____

<u>Insurance Information</u> - 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_____

Continue on back **Over**

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: _____