SCIENCE OLYMPIAD
NATIONAL TOURNAMENT 2014

PARTICIPANT MEDICAL INFORMATION AND RELEASE FORM

RETURN THIS FORM AT REGISTRATION CHECK IN
MAY 13-MAY 16, 2014

Please print in black or blue ink or type:

Participant FULL LEGAL Name, FIRST, LAST_____

Gender: _____ Date of Birth _____

The student may not have any medications (pill or oral liquid) in his/her possession. This includes over-the-counter medications like Tylenol. All medications must be given to and be held by a school representative, who will administer it according to the written instructions. If students carry an inhaler please attach a note to this form so stating and indicate what may necessitate its use. **All medications must be in the original container; the pharmacy label must be attached and clearly legibly for prescription drugs. All medications must be turned in at check-in.**

_____is not taking prescription medications.
_____is taking the following prescription medications.

Medication	Dosage	How Often/When?	For What?

Attach additional pages if necessary.

My child may have the following medication if needed. Check all that apply
Pain relief (Advil) ___ Cough medicine ___ Antacid ___ Other ___
These must be in original container and labeled with the child's name.

Please list any nonprescription (over-the-counter) drugs the student is taking or is permitted to take including aspirin, acetaminophen, antihistamines, etc.).

_____

_____

Doctor's approval is needed for prescription drugs.

Physician's Signature: _____
Initial if signed by Nurse or Physician's Assistant

The above-named student is
_____not covered by health and accident insurance.
_____covered by health & accident insurance as follows:

Policy Holder's Name _____

Relation to Student _____

Insurance Company _____

Group/Policy Number_____ Plan # _____

Insurance Company's Phone Number_____

Physician: _____Phone Number: _____

Allergies: (food, drugs, insects, plants, etc.) _____No _____Yes Explain:

_____

_____

Are immunizations current? _____No _____Yes

Date of last Tetanus injection: _____

Does student wear glasses or contact lens? _____No _____Yes

Please indicate if student experiences or has experienced any of the following. Attach an additional sheet if additional space is needed for details.

Problem	**Yes**	**No**	**Not Known**	**Details (i.e. how often, usual treatment, warning signs)**
Headaches				
Convulsions/Seizures				
Fainting Spells				
Vision Problems				
Hearing Problems				
Breathing Problems				
Heart Problems				
Blood Clotting Problems				
Stomach/Bowel Problems				
Skin Problems				
Frequent Infections				
Diabetes				

To the best of my knowledge the above information given is correct and my child has permission to engage in all Science Olympiad activities. In case of a medical emergency, I understand that I will be notified as soon as possible by the school representative. I hereby give permission to the physician selected by the Director or his designee to hospitalize, secure treatment for and to order injections, anesthesia or surgery for my child as named above. I also give permission for my child's school representative or staff to transport my child to the hospital or medical/dental office if needed. Any directions to the contrary should be specified at the bottom of this form and signed.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

Parent/Guardian Telephone Numbers Home (_____) _____

Work (_____) _____

Alternate Emergency Contact: Name_____

Relationship_____

Phone (_____) _____