



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 #: Home: Work: Cell: Email address

Father's Contact Information:

Name: Phone #: Home: Work: Cell: Email address

Other person's Contact Information: Relationship to participant

Name: Phone #: 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

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: _____