UNIVERSITY OF MARYLAND HEALTH CENTER
COLLEGE PARK, MD 20742

In order to provide your son/daughter medical care in the event of illness or injury, you are requested to complete this form.

Student's Name:_____ Age:_____

Name of Activity/Conference: ODYSSEY OF THE MIND WORLD FINALS

Dates of Attendance: From_____ To: _____

Father's Name: _____

Phone: Home: _____ Work: _____ Cell: _____

Mother's Name: _____

Phone: Home: _____ Work: _____ Cell: _____

Family Physician: _____ Telephone: _____

Insurance Information (Hospital Use Only)

Carrier: _____ Plan #: _____

Policy #: _____ Effect. Date: _____

Medical History

1. Date of last tetanus booster: _____

2. Allergies: Insect stings _____

   Foods _____

   Drugs _____

3. Is your child under the care of a physician for a medical problem?

   Yes ____ No ____ If yes, please explain: _____

   _____

4. Is your child taking medication prescribed by a physician? Yes ____ No ____

5. Other information we should be aware of: _____

   _____

Parental Permission

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter by the University of Maryland Health Center or any other medical facility. I understand that the health care facility will make every reasonable attempt to contact me first, time and conditions permitting. I agree to be responsible for all charges incurred.

Date: _____ Signer: _____

Relationship: _____