

# MEDICAL FORM TO BE COMPLETED BY PARENTS OR GUARDIANS

For Illinois Science Olympiad Tournaments

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ School \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Numbers (Home/Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_

## In an emergency, if unable to reach parent, please contact

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Does your child have any problems with the following, please circle the appropriate response:

Asthma	yes no	Environ. Allergies	yes no	Allergy to Insects	yes no
Seizures	yes no	Hearing Loss	yes no	Sleep Walking	yes no
Diabetes	yes no	Heart Problems	yes no	Strenuous Exercise	yes no
Allergies to food	yes no	Allergies to medications	yes no	Diet restrictions	yes no

Received all the required immunizations? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last tetanus shot: \_\_\_\_\_

Does your child have other serious medical problems or been under a physician's care recently? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes to any of the above problems, please, explain here or on an additional page: \_\_\_\_\_

**MEDICATIONS:** The student **may not** have **any** medications in his/her possession. This includes over-the-counter medications. 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 stating and indicate what may necessitate its use. **All medications must be in the original pharmacy container and must be delivered by the parent or guardian to the Science Olympiad Coach by a specified date to be announced.**

My child may have the following medication if needed (in original container, labeled with child's name). Check all that apply: Pain relief (Advil) \_\_\_\_\_ Cough medicine \_\_\_\_\_ Antacid \_\_\_\_\_ Other \_\_\_\_\_

List any prescription medications your child must take on a regular schedule.

Medication	Dosage	How Often?	When?

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 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 Coach 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.

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_

Date: \_\_\_\_\_