**Medical Form**

**New York State Science Olympiad, Inc.**

Parent/Guardian Must Complete This Form For Every Participant And/or Alternate Competing in a Tournament

Student's Name: _____ Birth Date: _____
Parent/Guardian: _____
Home Address: _____
Primary Phone Number: _____ Secondary Phone Number: _____
Primary Physician: _____ Phone Number: _____
Insurance Carrier: _____ Policy Number: _____
**In case of an emergency, and if unable to reach parent/guardian, please contact:**
Name: _____ Phone: _____
Name: _____ Phone: _____

Does your child have any problems with the following? Circle all that apply.

| | | | |
|---|---|---|---|
| Asthma | Hearing Loss | Environmental Allergies | Medication Allergies |
| Seizures | Heart Problems | Allergy to Insects | Food Allergies |
| Diabetes | Sleep Walking | Strenuous Exercise | Dietary Restrictions |

If yes, please explain here or on an additional page:

_____
_____
_____
_____

Does your child have any serious medical conditions or been under the care of a physician recently?

_____
_____
_____
_____
_____
_____

Has your child received all required immunizations? Yes_____ No_____ Date of last tetanus shot: _____

Students **may not have any** medication (pills, liquids, over-the-counter, etc.) in his/her possession, except as noted below. A school representative must hold all medications and administer according to the written instructions. If a student must carry an inhaler, Epi-pen, or other emergency medication, please attach a note to this form so stating.

My child may have the following medication if needed (Check all that apply; feel free to specify type).
Pain Relief _____ Cough Medicine _____
Antacid _____ Other _____

List any prescription medications your child must take on a regular schedule. These should be in original container and labeled with the child's name.

| Medication | Dosage | How Often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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 the school representative will notify me as soon as possible. I hereby give permission to the physician selected by the school representative or his/her 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 attached in a note to this form so stating.

Print Name: _____ Signature: _____
Date: _____