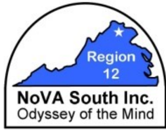

EMERGENCY CARE INFORMATION

Odyssey of the Mind Tournament, NoVA South Region 12, Manassas Park MS/HS **DATE:** _______________

STUDENT'S NAME: ____ **Date of Birth**: _________________

Address: ____

Father's Name: ____

Address: ____

Home Phone: ____________________ Work Phone: ___________________ Cell Phone: ___________________

Mother's Name: ____

Address (if different from above) :____

Home Phone: ____________________ Work Phone: ___________________ Cell Phone: ___________________

Legal Guardian: ____

Address: ____

Home Phone: ____________________ Work Phone: ___________________ Cell Phone: ___________________

Physician: ____ Phone: ___________________________

Insurance Information:

Carrier: _________________________________ Plan #______________ Policy # ________________________

Medical History

Allergies:

Insect stings ____

Food (please list) ____

Drugs (please list) ____

Medical conditions:

Please list any disabilities/conditions the coach should be aware of: ____________________________

____

Is your child currently under care of a physician for a medical problem? Yes ______ No ______

If yes, please explain on the bottom or back of this page

List all medications and dosages your child receives on a continual basis or is currently receiving:

____

Parental Permission:

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter by emergency services or hospital personnel. The medical staff has my authorization to provide treatment which a medical professional deems necessary for the well-being of my child. I agree to be responsible for all charges incurred.

Date: _____________ Signature:____________________________________ Relationship to student: ____________