



## 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: \_\_\_\_\_