TENNESSE SCIENCE OLYMPIAD
STATE TOURNAMENT 2017

PARTICIPANT MEDICAL INFORMATION AND RELEASE FORM

RETURN THIS FORM AT REGISTRATION CHECK-IN **MARCH 25, 2017**

Please print in black or blue ink or type:

Participant FULL LEGAL Name, FIRST, LAST _____

Gender: _____ Date of Birth: _____

The student may not have any medications (pill or oral liquid) in his/her possession. This includes over the counter medications. All medications must be given to and held by a school representative who will administer it according to the written instructions. If a student carries an inhaler please attach a note to this form so stating and indicate what may necessitate its use. **All medications must be in the original container; the pharmacy label must be attached and clearly legible for prescription drugs.**

_____ is not taking prescription medication(s).
_____ is taking the following prescription medication(s).

Medication	Dosage	How Often/When?	For What?

Please list any nonprescription (over-the-counter) drugs the student is taking or is permitted to take including aspirin, acetaminophen, antihistamines, etc.

_____

_____

The above-named student is
_____ not covered by health and accident insurance
_____ covered by health and accident insurance as follows:

Policy Holder's Name _____

Relation to Student _____

Insurance Company _____

Group Policy Number _____

Insurance Company's Phone Number _____

Physician: _____ Phone #:_____

Allergies: (food, drugs, insects, plants, etc.) _____ No _____ Yes

Explain: _____

_____

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Are immunizations current? _____ No _____ Yes

Date of last Tetanus injection: _____

Does the student wear glasses or contact lens? _____No _____ Yes

Please indicate if the student experiences or has experienced any of the following. Attach an additional sheet if more space is needed for details.

Problem	Yes	No	Not Known	Details (i.e. How often? Warning Signs? Usual Treatment?

PROBLEM	YES	NO	NOT KNOWN	DETAILS: i.e. How often? Warning signs? Treatment?
Headaches				
Convulsions/Seizures				
Fainting Spells				
Vision Problems				
Hearing Problems				
Breathing Problems				
Heart Problems				
Blood Clotting Issues				
Stomach/Bowel Issues				
Skin Problems				
Frequent Infections				
Diabetes				

To the best of my knowledge the above information is correct and my child has permission to engage in all Science Olympiad activities. In case of a 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 Director 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.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Parent/Guardian Telephone Numbers: Home _____
Work _____
Cell _____

Alternate Emergency Contact: Name _____
Relationship _____
Phone _____