

**PARTICIPANT MEDICAL INFORMATION AND RELEASE FORM  
TENNESSEE SCIENCE OLYMPIAD STATE TOURNAMENT**

**THIS FORM SHOULD BE RETURNED TO YOUR COACH SO THAT IT MAY BE  
SUBMITTED NO LATER THAN APRIL 1, 2019 WITH THE TEAM REGISTRATION**

SCHOOL : \_\_\_\_\_ Division: \_\_\_\_\_

**Please type or print in black or blue ink:**

Participant FULL LEGAL Name, FIRST, LAST: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

Alternate Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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 and when taken?	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: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Insurance Company's Phone Number: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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Participant FULL LEGAL Name, FIRST, LAST: \_\_\_\_\_

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

If yes, please explain: \_\_\_\_\_

Are immunizations current? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last Tetanus injection: \_\_\_\_\_

Does the student wear glasses or contact lens? Yes \_\_\_\_\_ No \_\_\_\_\_

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

<b>PROBLEM</b>	<b>YES</b>	<b>NO</b>	<b>NOT KNOWN</b>	<b>DETAILS: i.e. How often? Warning signs? Treatment?</b>
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