Science Olympiad MEDICAL RELEASE FORM – 2015-2016

Please fill out this form and return it to your school's Science Olympiad Head Coach. If your child gets sick or injured, this form will provide vital medical information for any issues that might arise on site. The coach or members of the San Diego Science Olympiad Board will try to contact you first, but completion of this form allows your child to be treated quickly even if you cannot be reached. ***At the end of the competition, this document will be disposed of in accordance with appropriate practices for confidential documents.***

Consent for Medical Treatment School:_____

_____

Name of Student (Please Print) First Name Last Name

_____ _____

Signature of Student Date

_____

Name of Parent/Guardian (Please Print) First Name Last Name

_____ _____

Signature of Parent or Guardian Date

For students less than 18 years of age, as parent or legal guardian of above student, I grant the following authorization for medical and/or surgical treatment of my child by a health care professional should the need arise while he/she is attending the SO Workshop at Bernardo Heights Middle School on November 14, 2015, Division B San Diego Regional Science Olympiad Competition at Carlsbad High School on February 6, 2016 OR the Division C San Diego Regional Science Olympiad Competition at University City High School on February 20, 2016.

For students over 18 years of age, I, the student above, grant the following authorization for medical and/or surgical treatment of myself by a health care professional should the need arise while I attend the SO Workshop at Bernardo Heights Middle School on November 14, 2015, Division B San Diego Regional Science Olympiad Competition at Carlsbad High School on February 6, 2016 OR the Division C San Diego Regional Science Olympiad Competition at University City High School on February 20, 2016. My birthdate was _____.

Please complete ONE of the following:

1. I grant permission to the directors, assistants, coaches or other persons responsible for my child's care to act on my behalf for said minor in granting permission for evaluation and treatment of medical or psychological problems. I understand that if a major medical or psychological problem arises, reasonable attempts will be made to notify me by telephone. In the event that I cannot be reached, I give my consent to such medical treatment as deemed necessary, including surgery, x-ray examinations, and anesthesia to be rendered to said minor by a licensed physician, physician's assistant, paramedic or nurse.

For students over 18 years of age, I grant permission for all of the above treatments for myself if I am unable to make those decisions.

DATE:_____ SIGNATURE:_____

Of Parent or Guardian of Minor – Or of Student > 18

2. I authorize limited medical care as follows:_____

_____

DATE:_____SIGNATURE:_____
Of Parent or Guardian of Minor – Or of Student > 18

3. I do **NOT** authorize medical care of any kind, except in case of an emergency.

DATE:_____SIGNATURE:_____
Of Parent or Guardian of Minor – Or of Student > 18

4. I do not authorize any medical care of any kind.

DATE:_____SIGNATURE:_____
Of Parent or Guardian of Minor – Or of Student > 18

Medical Information (All Participants)

Contact People (All Participants): In an emergency, parents or legal guardians can be reached as follows:

1. Contact Name:_____ Relationship to student**:** _____
Please print

Address:_____ **Home phone:** (_____) _____ - _____

City, Zip:_____ **Cell phone:** (_____) _____ - _____

2. Contact Name:_____ Relationship to student:_____
Please print

Address: _____ **Home phone:** (_____) _____ - _____

City, Zip:_____ **Cell phone:** (_____) _____ - _____

If other information would be helpful in contacting a necessary person, please indicate below:

_____

Insurance Information (All Participants)

Parents or legal guardians are responsible for the cost of a minor's medical treatment. (Students over 18 years of age are responsible for their own medical treatment.) When available, insurance information will be processed by the health facility performing the treatment; otherwise you will be contacted for payment by cash, check, or credit card. Treatment may be delayed if you cannot be reached to make payment arrangements, so we urge you to provide this information.

Insurance Company: _____

Insurance Company Address: _____

Group Number: _____ ID Number: _____

Policyholder's name: _____

Please list here **any other important health information**:
(i.e. Allergies, Medications, Medical Conditions, other Special Considerations)

_____

_____

When the Competitions are done, this document will be disposed of in accordance with recommended procedures for confidential documents.