

**Medical Form**  
**New York State Science Olympiad, Inc.**

Parent/Guardian Must Complete This Form For Every Participant And/or Alternate Competing in a Tournament

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

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

Primary Phone Number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

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

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**In case of an emergency, and if unable to reach parent/guardian, please contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child have any problems with the following? Circle all that apply.

- |          |                |                         |                      |
|----------|----------------|-------------------------|----------------------|
| Asthma   | Hearing Loss   | Environmental Allergies | Medication Allergies |
| Seizures | Heart Problems | Allergy to Insects      | Food Allergies       |
| Diabetes | Sleep Walking  | Strenuous Exercise      | Dietary Restrictions |

If yes, please explain here or on an additional page:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any serious medical conditions or been under the care of a physician recently?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child received all required immunizations? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last tetanus shot: \_\_\_\_\_

Students **may not have any** medication (pills, liquids, over-the-counter, etc.) in his/her possession, except as noted below. A school representative must hold all medications and administer according to the written instructions. If a student must carry an inhaler, Epi-pen, or other emergency medication, please attach a note to this form so stating.

My child may have the following medication if needed (Check all that apply; feel free to specify type).

Pain Relief \_\_\_\_\_ Cough Medicine \_\_\_\_\_  
Antacid \_\_\_\_\_ Other \_\_\_\_\_

List any prescription medications your child must take on a regular schedule. These should be in original container and labeled with the child's name.

Medication	Dosage	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

To the best of my knowledge the above information given is correct and my child has permission to engage in all Science Olympiad activities. In case of a medical emergency, I understand that the school representative will notify me as soon as possible. I hereby give permission to the physician selected by the school representative or his/her 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 attached in a note to this form so stating.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_