Odyssey of the Mind 2020 World Finals
Medical Information/Release Form

Participant Information

Last Name _____ First Name _____
Permanent Address _____ Date of Birth _____
Sex _____ City, State, Zip _____ Home Phone ( )_____

Event Information

Event Name and Description: _____Odyssey of the Mind World Finals_____
Event Dates (start and end dates): _____May 25-May 31, 2020_____

Medical Emergency Contact Information

Person to Contact First:
Name _____
Relation to Participant _____
Daytime Phone ( )_____
Evening Phone ( )_____

Back-up Contact (Friend or Relative):
Name _____
Relation to Participant _____
Daytime Phone ( )_____
Evening Phone ( )_____

Are you allergic to any medications? _____
List current prescriptions/medications: _____
Are you currently under a doctor's care? Please explain. _____
_____
_____

INSURANCE POLICY INFORMATION

____ Yes ____ No The above-named participant is covered by health insurance.
(If yes, provide the following information, which is required by Iowa State University to expedite treatment and to facilitate the billing process.)

Primary Policy Holder's(PH) Name _____ PH's Date of Birth _____
Address _____ Relation to Participant_____
City, State, Zip _____ Occupation _____
Phone Number:_____
PH's Employers Name _____
Employer Address _____

Insurance Company Name _____
Insurance Company Address _____
Policy #_____ Group/Plan #_____
Phone Number:_____

PARENTAL PERMISSION

On my behalf or for my underage child: I authorize the release of any medical information necessary to process claims submitted to the insurance companies I have provided to the Thielen Student Health Center. I also authorize payment of benefits to the clinic/physician or supplier of services rendered indicated on the billing document

Patient Signature: _____ Date _____

Parent/Guardian Name (Please Print) _____Relationship: _____
if patient is under 18 years old

Parent/Guardian Name Signature _____