MEDICAL FORM TO BE COMPLETED BY PARENTS OR GUARDIANS

For Illinois Regional Science Olympiad

Student's Name_____Birth Date _____

Parent or Guardian _____

Home Address: _____

Phone Numbers (Home)_____(Work)_____

Family Doctor: _____Phone _____

Insurance Carrier: _____Policy # _____

In an emergency, if unable to reach parent, contact

Name: _____Phone_____

Name: _____Phone_____

Does your child have any problems with the following, check all that apply:

	yes	no		yes	no		yes	no
Asthma	___	___	Environ. Allergies	___	___	Allergy to Insects	___	___
Seizures	___	___	Hearing Loss	___	___	Sleep Walking	___	___
Diabetes	___	___	Heart Problems	___	___	Strenuous Exercise	___	___

If yes to any of these, please, explain here or on an additional page:_____

_____

Does your child have other serious medical problems or been under a physicians care recently?

_____

If you answered yes to this question please explain: _____

_____

Does your child have any: allergies to food? _____
allergies to medications?_____
diet restrictions

_____

Has your child received all the required immunizations? Yes _____ No_____

What was the date of the last tetanus shot? _____

Continued on reverse side

MEDICATIONS

The student **may not** have **any** medications (pill or oral liquid) in his/her possession. This includes over-the-counter medications like Tylenol. All medications must be given to and be held by a school representative, who will administer it according to the written instructions. If students carry 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 pharmacy container and must be delivered by the parent or guardian to the Science Olympiad Coach by a specified date to be announced.**

My child may have the following medication if needed. Check all that apply

Pain relief (Advil) _____ Cough medicine _____ Antacid_____ Other _____

These should be in original container and labeled with the child's name.

List any prescription medications your child must take on a regular schedule.

Medication	Dosage	How Often?	When?

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 medical emergency, I understand that I will be notified as soon as possible by the school representative. I herby 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.

Print Name:_____ Signature _____

Date: _____