

**MEDICAL FORM TO BE COMPLETED BY PARENTS OR GUARDIANS**  
For New York State 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 any 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? \_\_\_\_\_

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## 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 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.

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

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