

INDIANA SCIENCE OLYMPIAD STATE TOURNAMENT
INDIANA UNIVERSITY BLOOMINGTON
March 29, 2008

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I, _____, BEING THE PARENT OR LEAGL GUARDIAN
OF _____ GRANT THE FOLLOWING AUTHORIZATION
FOR MEDICAL AND/OR SURGICAL TREATMENT OF THIS MINOR BY A HEALTH CARE PROFESSIONAL
SHOULD THE NEED ARISE WHILE HE/SHE IS ATTENDING THE RESEARCH EXPLORATION FOR HIGH
SCHOOL STUDENTS PROGRAM, FOR THE TIME PERIOD STARTING _____ AND ENDING
_____.

PLEASE COMPLETE ONE (1) OF THE FOLLOWING:

1. I GRANT PERMISSION TO THE DIRECTORS, ASSISTANTS, OR OTHER PERSONS RESPONSIBLE FOR HIS/HER CARE TO ACT ON MY BEHALF FOR SAID MINOR IN GRANTING PERMISSION FOR EVALUATION AND TREATMENT OF MEDICAL OR PSYCHOLOGICAL PROBLEMS. I UNDERSTAND THAT SHOULD A MAJOR MEDICAL OR PSYCHOLOGICAL PROBLEM ARISE, 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 OR NURSE.

DATE _____ SIGNATURE _____

2. I DO NOT WISH MEDICAL CARE OF ANY KIND, EXCEPT IN CASE OF AN EMERGENCY.

DATE _____ SIGNATURE _____

3. I AUTHORIZE LIMITED MEDICAL CARE AS FOLLOWS _____

DATE _____ SIGNATURE _____

MEDICAL INFORMATION (Please print)

PARTICIPANT'S NAME _____ SOCIAL SECURITY NUMBER _____

AGE _____ BIRTH DATE _____ DATE OF LAST TETANUS TOXOID _____

PAST HEALTH/INJURIES _____ PRESENT HEALTH _____

_____ ALLERGIC REACTIONS _____

_____ PRESENT MEDICATION _____

OTHER INFORMATION THAT WOULD BE USEFUL IN THE EVENT MEDICAL TREATMENT IS NECESSARY:

CONTACT INFORMATION (PLEASE PRINT)

IN AN EMERGENCY, PARENTS OR LEGAL GUARDIANS CAN BE REACHED AS FOLLOWS:

NAME _____ RELATIONSHIP TO MINOR _____

ADDRESS _____ DAYTIME PHONE _____

CITY/STATE/ZIP _____ EVENING PHONE _____

NAME _____ RELATIONSHIP TO MINOR _____

ADDRESS _____ DAYTIME PHONE _____

CITY/STATE/ZIP _____ EVENING PHONE _____

NAME _____ RELATIONSHIP TO MINOR _____

ADDRESS _____ DAYTIME PHONE _____

CITY/STATE/ZIP _____ EVENING PHONE _____

INSURANCE INFORMATION (PLEASE PRINT)

PARENTS OR LEGAL GUARDIANS ARE RESPONSIBLE FOR THE COST OF A MINOR'S 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.

INSURANCE COMPANY _____ ADDRESS _____

CITY/STATE/ZIP _____ RELATIONSHIP TO MINOR _____

POLICY HOLDER'S NAME _____ POLICY NUMBER _____