WISCONSIN SCIENCE OLYMPIAD

CONSENT FOR MEDICAL TREATMENT OF A MINOR

Wisconsin Science Olympiad State, Regional & Invitational Tournaments

School Name: _____

Student Name: _____

NOTE: No competitor will be allowed to compete unless this form is completely filled out and signed by a parent or guardian. We WILL be inspecting all forms at registration.

The Team Coach will keep this form in their possession.

I, _____, BEING THE PARENT OR LEGAL 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 WISCONSIN SCIENCE OLYMPIAD TOURNAMENT.

I GRANT PERMISSION TO THE COACHES 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.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE COSTS OF TREATMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY BENEFITS DIRECTLY TO THE HEALTH CARE PROVIDERS. ALSO, I AUTHORIZE THE DISCLOSURE OF MEDICAL INFORMATION TO THE INSURANCE COMPANY FOR THE PURPOSE OF SUBMITTING A CLAIM.

Date _____ Signature of parent/legal guardian _____

Phone # of parent/legal guardian: _(____)_____

Insurance Company: _____

Policy Number: _____

Known medical conditions: _____

This authorization is effective for:
Wisconsin Division C and B 2023-2024 Science Olympiad Sanctioned Tournaments

THIS FORM MUST BE PRESENTED FOR INSPECTION AND CHECK-OFF AT REGISTRATION BEFORE THE COMPETITION.

Note: If a school district also requires and has these forms or similar documentation, these will be accepted at Tournaments