Odyssey of the Mind 2022 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 24-28 2022______________________________________

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

Please complete the additional form requesting insurance information. In the event that you need to be treated at a location other than the Thielen Health Center, please indicate below your approval for your information to be used at alternate medical facilities.

PARENTAL/GUARDIAN 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: ____________

IOWA STATE UNIVERSITY
Thielen Student Health Center

2647 Union Drive
Ames, Iowa 50011
Phone: 515-294-5801
Fax: 515-292-9135

Odyssey of the Mind Medical Insurance Information

SUBMIT INSURANCE THREE WAYS:

1. *Scan and email to: submitinsurance@iastate.edu*
2. *Drop off at the Student Health Center, corner of Union drive and Sheldon Avenue*
3. *Mail to: Student Health, ATTN: Insurance Information, Thielen Student Health Center, 2647 Union Drive, Ames, Iowa 50011-2029*

Patient Information:

Patient Full Name:	
Date of Birth (MM/DD/YYYY): Age:	

Legal Representative Information:

Full Name:	
Date of Birth (MM/DD/YYYY):	Relationship to Patient:
Phone #:	Email:

☐ I am **NOT** covered by any insurance polices. ______________________________

STOP and SIGN statement - DO NOT complete rest of form. *Patient's Signature and Date*

☐ I have the following types of insurance: (*check all that apply*) ☐ **MEDICAL** ☐ **PHARMACY**

If the patient is covered under **more than one plan**, please **list the primary insurance** in the space provided below. **Provide any secondary insurance information** - such as the policy holder information for this secondary plan on the back of this form.

PLEASE ATTACH A COPY OF ALL ACTIVE INSURANCE CARDS (FRONT AND BACK).

Medical Insurance Information: (ALL INFORMATION BELOW IS REQUIRED)

Primary Policyholder's Full Name:		
Relationship to Patient:		
Phone Number:	Date of Birth (MM/DD/YYYY):	
Address:		
City:	State:	Zip:

Complete only if information is not located on copy of insurance card:

Insurance Company:	Phone Number:	
Address:		
City:	State:	Zip:
Policy Number:	Group Number:	

Billing Information

Name:		
Address:		
City:	State:	Zip:

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's Printed Name **Today's Date (MM/DD/YYYY)**

______________________________ ______________________________

Signature of Patient (or Legal Representative, if applicable)

If applicable, Legal Representative's Printed Name and Relation to Patient (e.g., Mother, Father, Guardian, etc.) or signature of witness (witness not required in Iowa, but may be in other states).