

PARTICIPANT INFORMATION

Participant's Name _____

Social Security # _____

Permanent Address _____

Date of Birth _____ Sex _____

City, State, Zip _____

Home Phone () _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First:

Backup Contact (Relative or Friend):

Name _____

Name _____

Relation to Participant _____

Relation to Participant _____

Daytime Phone () _____

Daytime Phone () _____

Evening Phone () _____

Evening Phone () _____

Is he/she allergic to any medications? _____

List current prescriptions/medications _____

INSURANCE POLICY INFORMATION

Yes ___ No___ The above-named participant is covered by health insurance.

If yes, provide the following information, which is required by some sites, to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____

Address _____ Relation to Participant _____

City, State, Zip _____ Occupation _____

P.H.'s Employer's Name _____

Employer Address _____

Insurance Company Name _____

Insurance Company Address _____

Policy # _____ Plan # _____

I give permission for my child, _____

to attend the Destination Imagination regional competition in _____ on _____ and (if

applicable) the state competition in Grinnell . I give _____

permission to seek emergency medical attention for my child if needed. On the back of this form I have

listed any other vital health information an ER physician should know about my child.

Parent Signature: _____ Date: _____