Parental Consent Form

I, (Mr., Mrs., Ms.) ________________________ (Guardian's Full Name),
the legal guardian of ________________________ (Student's Full Name),
give my consent for him/her to participate in all activities associated with the 2017 National Ocean Sciences Bowl. I understand that this will include participation in special events and activities related to the 2017 National Ocean Sciences Bowl, and will include travel under the supervision of the team coach.

I hereby release and discharge the Consortium for Ocean Leadership, their officers, agents, servants, and employees, and persons, firms, or corporations contracting with, or acting on behalf of, the Consortium for Ocean Leadership, with respect to the activities of the 2017 National Ocean Sciences Bowl, as well as their heirs, executors, administrators, successors, or assigns, from any cause of action of any nature whatsoever arising from my child's participation in the activities of the 2017 National Ocean Sciences Bowl.

______________________________
Signature of Legal Guardian (if under 18 years old)  Date

______________________________
Signature of Student (if over 18 years old)  Date

Parental Media Consent

I hereby authorize and give full consent for ________________________ (Student's Full Name) to be interviewed, photographed, and/or used in written materials used by the Consortium for Ocean Leadership and any of its affiliated programs. Ocean Leadership may copyright or publish photographs taken and/or statements made by the above signed, both written and verbal. I further agree that Ocean Leadership, or any of its affiliated programs with their permission, may use or cause to be used these statements and/or photographs for any or all exhibitions, public displays, publications and any other promotional venues, without limitation, reservation or compensation.

I understand that any final editing of any interview/photography/written materials done by the news media is not within the control of Ocean Leadership, and Ocean Leadership does not have responsibility for the story that appears on radio/television/newspaper/internet. Written materials, photographs, or video files created by or submitted to Ocean Leadership become the property of this organization and will not be returned to the author/owner/talent.

______________________________
Signature of Legal Guardian (if under 18 years old)  Date

______________________________
Signature of Student (if over 18 years old)  Date

Regional Recruitment Consent

☐ By checking this box, I understand the regional competition host (university or college) may contact him/her for the purpose of undergraduate recruitment.
2020 Regional Competitions

***Please make a copy of the completed form for your records. If your team advances to the NOSB Finals, this form will be required and you may need to resend it to the National office.***

Student Medical Information and Emergency Notification Form

Name: ___________________________ Date of Last Tetanus Shot: ___________________________

Birthdate: ___________ Sex: M F

Drug Allergies: ____________________________________________________________________

Street Address: ___________________________________________________________________

City: __________________ State: ___________ Zip Code: ___________

Home Telephone: ___________________ Cell Phone: ___________________

Date of Last Tetanus Shot: __________________________________________________________

Drug Allergies: ____________________________________________________________________

Physician: ___________________________ Phone: ___________________

Medical Conditions or Previous Surgery: _______________________________________________

Regular Medications: ___________________________________________________________________

Special Dietary Requirement (include food allergies): ______________________________________

Do you require or prefer a vegetarian Meal:  Y  N  Do you require or prefer a vegan meal:  Y  N

Special Physical Needs: ___________________________________________________________________

Family Information

Parent/Legal Guardian’s Name: _________________________________________________________

Parent/Legal Guardian Cell Phone (required): ___________________________

Work phone: _______________________________________________________________________

Emergency Contact: _________________________________________________________________

Cell Phone: ___________________ Alternate Phone: ___________________

Relationship to student: ___________________________________________________________________

Medical/Hospital Insurance Carrier: ___________________________ Policy #: ___________________

Toll-free number: ______________________________________________________________________

CONSENT TO MEDICAL CARE AND TREATMENT

Parental consent is required before a hospital’s emergency department can give medical treatment to a minor. Every effort will be made to contact parents, but a completed consent form will expedite treatment.

I hereby authorize and consent to the administration of all medical and/or surgical treatment(s) to my child by a licensed physician or hospital in the event I am not available to consult with attending physician(s), attempts to contact me have been unsuccessful, and the attending physician(s) deem it advisable to proceed with such treatment(s).

________________________________________________________________________________

Signature of Legal Guardian (if under 18 years old) Date

________________________________________________________________________________

Signature of Student (if over 18 years old) Date
Coach Media Consent

I ____________________________________ hereby authorize and give full consent
(Full Name)

for the Consortium for Ocean Leadership and any of its affiliated programs to interview,
photograph, and/or use my name and affiliation in written materials about the program.
Ocean Leadership may copyright or publish photographs taken and/or statements made
by the above signed, both written and verbal. I further agree that Ocean Leadership, or
any of its affiliated programs with their permission, may use or cause to be used these
statements and/or photographs for any or all exhibitions, public displays, publications
and any other promotional venues, without limitation, reservation or compensation.

I understand that any final editing of any interview/photography/written materials done
by the news media is not within the control of Ocean Leadership, and Ocean
Leadership does not have responsibility for the story that appears on
radio/television/newspaper/internet. Written materials, photographs, or video files
created by or submitted to Ocean Leadership become the property of this organization
and will not be returned to the author/owner/talent.

____________________________________________________________________
Coach’s Signature                               Date
2020 Regional Competitions

***Please make a copy of the completed form for your records. If your team advances to the NOSB Finals, this form will be required and you may need to resend it to the National office.***

Coach Confidential Medical Information and Emergency Notification Form

Name: ________________________________________ Birthdate: ____________ Sex: M F

Street Address: ____________________________________________

City: ___________________________ State: __________________ Zip Code: ____________

Home Telephone: ___________________________ Cell Phone: ___________________________

Date of Last Tetanus Shot: ____________ Drug Allergies: __________________________________

Physician: ___________________________________________ Phone Number: ________________

Medical Conditions or Previous Surgery: __________________________________________________

Regular Medications: __________________________________________________________________

Special Dietary Requirement (include food allergies): _________________________________________

Do you require or prefer a vegetarian meal?  Y  N  Do you require or prefer a vegan meal?  Y  N

Special Physical Needs: __________________________________________________________________

Emergency Notification Information

Emergency Contact: __________________________________________ Phone: __________________

Relationship: __________________________________________________________________________

Medical/Hospital Insurance Carrier: _________________________ Policy #: _________________

Toll-free number: _______________________________________________________________________

CONSENT TO MEDICAL CARE AND TREATMENT

I hereby authorize and consent to the administration of all medical and/or surgical treatment(s) by a licensed physician or hospital in the event I am not available to consult with attending physician(s) and the attending physician(s) deem it advisable to proceed with such treatment(s).

__________________________________________________________
Coach Signature  ____________________________
Date