All required forms must be received prior to scheduling travel arrangements for the National finals.

U.S. DEPARTMENT OF ENERGY
2008 National Science Bowl® for High School Students
Adult Confidential Medical Information and Emergency Notification Form
(Please fill out the entire 3-page form)

This is a PDF Form filler document. Click on the space and type in the information requested. Once the form is complete: (1) click "File," then "Save As" and give it a name and save it on your computer; (2) print the completed form; (3) must sign it in blue ink (preferred).

School_____

Name_____ Birth Date _____Sex: M _____F_____

Street Address_____

City_____ State_____ Zip Code_____

Home Telephone (___)_____ SSN_____
(only necessary for National event)

IN CASE OF EMERGENCY, CONTACT:

Primary Contact		Secondary
_____	Name	_____
(___) _____	Phone	(___) _____
(___) _____	Cell Phone	(___) _____
_____	Relationship	_____

Allergies

Yes	No		If Yes, specify
___	___	Medication:	_____
___	___	Food	_____
___	___	Environmental	_____

Medical History (To include surgeries)

Date of Last Tetanus Shot:_____

(A) Current/Recent Medical History/surgery (within the past 12 months)

_____

_____

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(B) Previous Medical History/surgery (please include ALL medical history beyond 12 months)

_____
_____
_____
_____

Medication Information (Prescribed and Over-the-Counter Medications and Purpose)
Follow the format listed below.

Prescribed Medications

Medication/Dosage	Purpose/Used For
(Example: Albuterol/10mg per day)	(Example: Asthma)

Over the Counter

Medication	Purpose/Used For
(Example: Advil/as needed)	(Example: Headaches)

Physical Limitations/Needs (Please include any Assistive Devices that need to be provided):

Mobility Limitations _____
Visual Limitations _____
Communications Limitations _____

Vegetarian/Kosher Diet Preferences:_____

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Religious or Cultural concerns that may affect care: (e.g. No Blood Transfusions)

_____

HEALTH INSURANCE

YES _____ **NO _____** **If, Yes, complete the following:**

Physician	**Contact**	**Insurance**
_____	**Name**	_____
( ) _____	**Phone**	( ) _____
	Policy #	_____

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, nurse or hospital in the event I am not available to consult with the attending physician(s) and the attending physician(s) deem it advisable to proceed with such treatment(s).

_____
(Print Name)

_____ **Date** _____
Signature in Blue Ink

NO FAX COPIES