Print Form

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 Middle 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) you must sign the form in ink (blue is 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
(Example: Albuterol/10mg per day)	(Example: Asthma)

Over the Counter

Medication	Purpose/Used
(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)

_____ _____

Signature in Blue Ink Date

NO FAX COPIES