2009 NEVADA REGIONAL SCIENCE BOWL

HOSTED BY THE NATIONAL NUCLEAR SECURITY ADMINISTRATION, NEVADA SITE OFFICE

Student Confidential Medical Information and Emergency Notification Form

Parent/guardian or student (if 18 years old) must complete and sign in blue ink (preferred). Give this form to the coach; coach to give all completed forms to the regional coordinator by **November 14, 2008**.
Please fill out the entire 2-page form.

Name: _____ Birth Date: _____ Sex: M ☐ F ☐

Street Address: _____ City: _____ State: ____ Zip Code: _____

Home Telephone: (___) _____

IN CASE OF EMERGENCY - CONTACT INFORMATON

Primary

Name: _____

Phone: _____

Cell phone: _____

Work phone: _____

Relationship: _____

Secondary

Name: _____

Phone: _____

Cell phone: _____

Work phone: _____

Relationship: _____

HEALTH INSURANCE

YES ☐ No ☐ If yes, complete the following:

Physician

Name: _____

Phone: _____

Insurance

Insurance name: _____

Phone: _____ **Policy #:** _____

MEDICAL HISTORY

(To include surgeries)

Date of last Tetanus Shot: _____

(A) Current/recent medical history/surgery (within the past 12 months): _____

_____

(B) Previous medical history/surgery (please include ALL medical history beyond 12 months): _____

_____

_____

Yes	No	*If yes, please explain*:
☐	☐	Medication allergies: _____
☐	☐	Environmental allergies: _____
☐	☐	Food allergies: _____

NO FAX COPIES

RETURN BY NOVEMBER 14, 2008
NO FAX COPIES

Nevada Regional Science Bowl
Saved as: SBStudentMedical2009

2009 NEVADA REGIONAL SCIENCE BOWL
HOSTED BY THE NATIONAL NUCLEAR SECURITY ADMINISTRATION, NEVADA SITE OFFICE

Continued on page 2

MEDICATION INFORMATION
(Prescribed and over-the-counter medications and purpose)

Prescribed medications:

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

Over-the-counter medications:

Medication/Dosage	Purpose/Used
(Example: Advil/as needed)	(Example: Headache)

Physical limitations/needs (Please include any assistive devices that need to be provided):

Mobility limitations: _____

Visual limitations: _____

Communications limitations: _____

Vegetarian/kosher diet preferences: _____

Religious or cultural concerns that may affect care: (e.g. No blood transfusions): _____

_____

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 for 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 the attending physician(s), attempts to contact me have been unsuccessful, and the attending physician(s) deem it advisable to proceed with such treatments(s).

_____ _____

Print name of parent or legal guardian **Print name of student**

Signature of parent or legal guardian: _____ **Date:** _____

NO FAX COPIES

RETURN BY NOVEMBER 14, 2008
NO FAX COPIES

Nevada Regional Science Bowl
Saved as: SBStudentMedical2009