U.S. DEPARTMENT OF ENERGY
2013 National Science Bowl®
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) please sign the form in blue ink.

School ____

Name ______________________________ Birth Date _____________ Sex: M ____ F ____

Street Address ____

City ______________________________ State ____________ Zip Code ____________

Home Telephone (____) ______________________________

SSN (*only necessary for adults attending the National event*): __________________________

PLEASE LIST TWO EMERGENCY CONTACTS:

	Primary Contact			**Contact #2**
Name:			**Name:**	
Phone:			**Phone:**	
Cell Phone:			**Cell Phone:**	
Relationship:			**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)

____

____

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

____

____

____

____

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

Current Prescribed Medications – PLEASE PRINT!

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

Current Over the Counter Medications – PLEASE PRINT!

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 ______________________________

Dietary Restrictions (vegetarian, kosher, etc.): ________________________________

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

PHYSICIAN & HEALTH INSURANCE

Physician's Name: ____________________ **Phone Number:** ____________________

Do you have Health Insurance? YES _____ NO _____
If Yes, complete the following:

Insurance Company: ________________________________

Policy Number: ____________________ **Phone 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, 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 Ink

*Please return completed forms to regional coordinator **prior** to event:*

U.S. Mail: Science Bowl
Attn: Deb Samuelson
Ames Laboratory, 111 TASF
Ames, IA 50011

OR

SCAN/Email: debsam@ameslab.gov

OR

FAX: 515-294-3226