U.S. DEPARTMENT OF ENERGY
2013 National Science Bowl®
Student Confidential Medical Information and Emergency Notification Form
(Please fill out the entire 3-page form)

To complete: 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) parent/guardian or student (if 18) must sign it in ink; (4) return this form to the coach.

School_____

Name _____ Birth Date _____ Sex: M ____ F ____

Street Address_____

City _____ State _____ Zip Code _____

Home Telephone (____)_____

SSN (***only necessary for students attending the National event***): _____
If this number is NOT provided, the student may NOT be allowed to attend or compete in the final rounds of the National Science Bowl in Washington, DC.

PLEASE LIST TWO EMERGENCY CONTACTS:

	Primary Contact (#1)			**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

(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, nurse 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 treatment(s).

_____
(**Print** Name of Parent or Legal Guardian)

_____
(**Print** Name of Student)

_____ **Date** _____
Signature of Parent/Legal Guardian (or Student if 18 years of age)

*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