

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) 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:

<u>Primary</u>	<u>Contact</u>	<u>Secondary</u>
_____	Name _____	_____
() _____	Phone () _____	_____
() _____	Cell Phone () _____	_____
_____	Relationship _____	_____

Allergies

Yes	No	If Yes, specify
<input type="radio"/>	<input type="radio"/>	Medication: _____
<input type="radio"/>	<input type="radio"/>	Food _____
<input type="radio"/>	<input type="radio"/>	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:

<u>Physician</u>	<u>Contact</u>	<u>Insurance</u>
	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