

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**
Student 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) parent/guardian or student (if 18) must sign it in blue ink (preferred); (4) give this form to the coach; (5) coach to give all completed forms to the regional coordinator.

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

(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)

Signature of Parent/Legal Guardian (or Student if 18) in Blue Ink

Date _____

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