

All required forms must be received prior to scheduling travel arrangements for the National finals.

**U.S. DEPARTMENT OF ENERGY**  
**2012 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:**

|                      | <u>Primary Contact (#1)</u> |                      | <u>Contact #2</u> |
|----------------------|-----------------------------|----------------------|-------------------|
| <b>Name:</b>         |                             | <b>Name:</b>         |                   |
| <b>Phone:</b>        |                             | <b>Phone:</b>        |                   |
| <b>Cell Phone:</b>   |                             | <b>Cell Phone:</b>   |                   |
| <b>Relationship:</b> |                             | <b>Relationship:</b> |                   |

**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)

\_\_\_\_\_  
\_\_\_\_\_

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

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**Medication Information (Prescribed and Over-the-Counter Medications and Purpose)**

Please follow the format listed below.

**Current Prescribed Medications**

| <b>Medication/Dosage</b>          | <b>Purpose/Used For</b> |
|-----------------------------------|-------------------------|
| (Example: Albuterol/10mg per day) | (Example: Asthma)       |
|                                   |                         |
|                                   |                         |
|                                   |                         |
|                                   |                         |
|                                   |                         |
|                                   |                         |
|                                   |                         |
|                                   |                         |
|                                   |                         |

**Current Over the Counter Medications**

| <b>Medication</b>          | <b>Purpose/Used For</b> |
|----------------------------|-------------------------|
| (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)** \_\_\_\_\_

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**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)

\_\_\_\_\_  
Signature of Parent/Legal Guardian (or Student if 18 years of age)      Date \_\_\_\_\_

**NO FAX COPIES**