For the National Finals, all required forms must be received within 2 weeks of the Regional Competition, or by March 19, 2018, whichever occurs first. Failure to submit the required forms on time will result in the participant's loss of eligibility to compete.

***Regional WINNING Teams**: Upload this form to Norma Ward (information below)*

***ALL OTHER TEAMS**: Send this form to your Regional Coordinator*

U.S. DEPARTMENT OF ENERGY
2018 National Science Bowl®
Adult Confidential Medical Information and Emergency Notification Form
(Please fill out the entire 4-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.

☐ Coach ☐ Co-coach ☐ NSB Alumnus ☐ Regional Coordinator ☐ Other

School _____

Name _____ Birth Date _____ Gender: M ☐ F ☐

Street Address _____

City _____ State _____ Zip Code _____

Home Telephone (____) _____

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	_____

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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)

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Physical Limitations/Needs (Please include any assistive devices that need to be provided):

Mobility Limitations _____

Visual Limitations _____

Communications Limitations _____

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

If you have severe dietary restrictions, please list samples of meals that you CAN eat:

_____

_____

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:** _____

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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) deems it advisable to proceed with such treatment(s).

_____

(**Print** Name)

_____ **Date** _____

Signature in Ink

Please return this form to your Regional Coordinator.

For the **REGIONAL WINNING TEAMS**, upload the completed form to:

https://sawd.orau.org/nsbforms

For National Competition questions please contact Norma Ward at **nsb@orise.orau.gov**

OFFICIAL USE ONLY

May be exempt from public release under the Freedom of Information Act (5 U.S.C. 552), exemption number and category: 6, Personal Privacy

Department of Energy Review required before public release
Name/Org: Allen Wash/ORISE Date: 1/1/2018
Guidance (if applicable): CG-SS-5

Name _____