

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.

___ Staff ___ NSB Alumnus ___ Regional Coordinator ___ Other

Name _____ Birth Date _____ Gender: M ___ F ___

Street Address _____

City _____ State _____ Zip Code _____

Home Telephone (____) _____

PLEASE LIST TWO EMERGENCY CONTACTS:

	<u>Primary Contact</u>		<u>Contact #2</u>
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)

Name _____

(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 _____

Name _____

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: _____

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 the completed form to:

Ms. Norma Ward ~ Oak Ridge Associated Universities ~ P.O. Box 117/MS-36

Oak Ridge, TN 37831-0117 ~ Phone: 865-241-2890

REGIONAL WINNING TEAMS may also fax this secure fax number: (865) 576-4197

Name _____