*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 OFFICE OF SCIENCE**
**2018 National Science Bowl®**

# Student Confidential Medical Information and Emergency Notification Form

**(Please fill out the entire 4-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 or via Adobe Sign; (4) return this form to the coach.

School___________________________________________

Name ______________________________ Birth Date _____________ Sex: M ____ F ____

Street Address ________________________________________________________

City ______________________________ State ____________ Zip Code ____________

Home Telephone (include area code): _______________________________________

**PLEASE LIST TWO EMERGENCY CONTACTS:**

| | **Primary Contact (#1)** | | | **Contact #2** |
|---|---|---|---|---|
| **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:_______________

Name ___________________________________

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(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) |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Name ___________________________________

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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:** _____________________

Name ________________________________

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## CONSENT TO MEDICAL CARE AND TREATMENT

**Authorization to Arrange for Medical Care:**
**I hereby give permission to the U.S. Department of Energy and ORAU to send my child for emergency room treatment and to call his/her primary physician if necessary.**

____________________________________________
(**Print** Name of Parent or Legal Guardian)

____________________________________________
(**Print** Name of Student)

__________________________________________________ **Date** __________________
**Signature of Parent/Legal Guardian (or Student if 18 years of age)**

***(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)

__________________________________________________ **Date** __________________
**Signature of Parent/Legal Guardian (or Student if 18 years of age)**

**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 __________________________________