U.S. DEPARTMENT OF ENERGY
National Science Bowl®
2024 Adult 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) please sign the form in blue ink.

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 ____

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 or Adobe Entrust

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Department of Energy Review required before public release Name/Org: Allen Wash/ORISE Date: 9/15/2022 Guidance (if applicable): CG-SS-5