For the National Finals, all required forms must be received within 2 weeks of the Regional Competition, or by March 18, 2020, whichever occurs first. Failure to submit the required forms on time will result in the participant's loss of eligibility to compete.

U.S. DEPARTMENT OF ENERGY OFFICE OF SCIENCE
2020 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:_____

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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:** _____

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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)

For National Science Bowl® Regional Competition Use - Please return the completed form to the Regional Coordinator OR upload the completed form to the team's registration page: https://apps.orau.gov/nsb-coach/Account

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Name _____