

U.S. DEPARTMENT OF ENERGY
National Science Bowl®
2023 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:

	<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 _____

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

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: 9/15/2022 Guidance (if applicable): CG-SS-5

Name _____