U.S. DEPARTMENT OF ENERGY
National Science Bowl®
2027 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.

Nam _____ 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)

_____

_____

(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