

2010 NEVADA REGIONAL SCIENCE BOWL
HOSTED BY THE NATIONAL NUCLEAR SECURITY ADMINISTRATION, NEVADA SITE OFFICE

Adult Confidential Medical Information and Emergency Notification Form

Must complete and sign in blue ink (preferred). Give this form to regional coordinator by **November 12, 2009**.
Please fill out the entire 2-page form.

Name: _____ Birth Date: _____ Sex: M F

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone: (____) _____

IN CASE OF EMERGENCY - CONTACT INFORMATION

Primary

Secondary

Name: _____

Name: _____

Phone: _____

Phone: _____

Cell phone: _____

Cell phone: _____

Work phone: _____

Work phone: _____

Relationship: _____

Relationship: _____

HEALTH INSURANCE

Yes No If yes, complete the following:

Physician

Insurance

Name: _____

Insurance name: _____

Phone: _____

Phone: _____ Policy #: _____

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): _____

Yes No *If yes, please explain:*
Medication allergies: _____

Environmental allergies: _____

Food allergies: _____

NO FAX COPIES

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RETURN BY NOVEMBER 12, 2009
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Nevada Regional Science Bowl
Saved as: SBCoachMedical2010

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MEDICATION INFORMATION
 (Prescribed and over-the-counter medications and purpose)

Prescribed medications:

| Medication/Dosage | Purpose/Used |
|-----------------------------------|-------------------|
| (Example: Albuterol/10mb per day) | (Example: Asthma) |
| | |
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| | |
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Over-the-counter medications:

| Medication/Dosage | Purpose/Used |
|----------------------------|---------------------|
| (Example: Advil/as needed) | (Example: Headache) |
| | |
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| | |

Physical limitations/needs (Please include any assistive devices that need to be provided):

Mobility limitations: _____

Visual limitations: _____

Communications limitations: _____

Vegetarian/kosher diet preferences: _____

Religious or cultural concerns that may affect care: (e.g. No blood transfusions): _____

CONSENT TO MEDICAL CARE AND TREATMENT

(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 for 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 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 treatments(s).

_____ **Print name**

Signature in blue ink: _____ **Date:** _____

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