

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

Student Confidential Medical Information and Emergency Notification Form

Parent/guardian or student (if 18 years old) must complete and sign in blue ink (preferred). Give this form to the coach; coach to give all completed forms to the 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

<u>Primary</u>	<u>Secondary</u>
Name: _____	Name: _____
Phone: _____	Phone: _____
Cell phone: _____	Cell phone: _____
Work phone: _____	Work phone: _____
Relationship: _____	Relationship: _____

HEALTH INSURANCE

YES No If yes, complete the following:

<u>Physician</u>	<u>Insurance</u>
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 <input type="checkbox"/>	No <input type="checkbox"/>	<i>If yes, please explain:</i>
<input type="checkbox"/>	<input type="checkbox"/>	Medication allergies: _____
<input type="checkbox"/>	<input type="checkbox"/>	Environmental allergies: _____
<input type="checkbox"/>	<input type="checkbox"/>	Food allergies: _____

NO FAX COPIES

RETURN BY NOVEMBER 12, 2009
NO FAX COPIES

Nevada Regional Science Bowl
Saved as: SBStudentMedical2010

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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)

Over-the-counter medications:

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

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 of parent or legal guardian

 Print name of student

Signature of parent or legal guardian: _____ Date: _____

NO FAX COPIES