2019 NEVADA REGIONAL SCIENCE BOWL

HOSTED BY THE NATIONAL NUCLEAR SECURITY ADMINISTRATION, NEVADA FIELD OFFICE

Adult Emergency Information Form

Must complete and sign in blue ink (preferred). Give this form to regional coordinator by the registration deadline. Please fill out the entire 3-page form.

Name: ____________________________________ Birth Date: _________________________ Sex: M F

Street Address: ______________________________ City: ________________ State: ____ Zip Code: _________

Home Telephone: (___)____________________

IN CASE OF EMERGENCY - CONTACT INFORMATION

Primary

Name: ____

Phone: ____

Cell phone: ____

Work phone: ____

Relationship: ____

Secondary

Name: ____

Phone: ____

Cell phone: ____

Work phone: ____

Relationship: ____

HEALTH INSURANCE

Yes No If yes, complete the following:

Physician

Name: ____

Phone: ____

Insurance

Insurance name: ______________________________________

Phone: ____________________**Policy #:** __________________

OPTIONAL MEDICAL INFORMATION

(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): _____________________________

____

____

Personal concerns that may affect care: (e.g. No blood transfusions): _________________________

____

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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)

ALLERGY INFORMATION - REQUIRED

Yes No *If yes, please explain*:

Yes No Medication allergies: ____________________

Yes No Environmental allergies: ____________________

Yes No Food allergies: ____________________

Vegetarian/kosher diet preferences: ____________________

Accommodation requests (Please include any assistive devices that may need to be provided):

Mobility assistance: ____________________

Visual assistance: ____________________

Communications assistance: ____________________

Other: ____________________

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CONSENT TO MEDICAL CARE AND TREATMENT

(Consent is required before a hospital's emergency department can provide medical treatment. Every effort will be made to contact emergency contacts, 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 myself by a licensed physician or hospital in the event I am unable to consult with the attending physician(s), attempts to contact my emergency contacts have been unsuccessful, and the attending physician(s) deem it advisable to proceed with such treatments(s).

This authorization is valid for 02/01/19-02/02/19

____

Print name

Signature in blue ink: ____ **Date:** ____________________________

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