

2019 NEVADA REGIONAL SCIENCE BOWL

HOSTED BY THE NATIONAL NUCLEAR SECURITY ADMINISTRATION, NEVADA FIELD OFFICE

Student Emergency Information Form

Parent/guardian or student (if 18 years old) must complete and sign in blue ink (preferred). Give this form to the coach; form may be provided to coach in a sealed envelope marked "Confidential"; coach to give all completed forms to the 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): _____

NO FAX COPIES

RETURN BY REGISTRATION DEADLINE
NO FAX COPIES

Nevada Regional Science Bowl
Saved as: SBSStudentMedical2019

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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

(Parental consent may be required before a hospital's emergency department or other medical provider can give medical treatment to a minor. Every effort will be made to contact parents, 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 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).

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

Print name of parent or legal guardian

Print name of student

Signature of parent or legal guardian: _____ Date: _____

NO FAX COPIES