

2017 NEVADA SCIENCE BOWL

HOSTED BY THE NATIONAL NUCLEAR SECURITY ADMINISTRATION, NEVADA FIELD 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 coordinator by the registration deadline.

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:*

Yes No Medication allergies: _____

Yes No Environmental allergies: _____

Yes No Food allergies: _____

NO FAX COPIES

RETURN BY REGISTRATION DEADLINE
NO FAX COPIES

Nevada Science Bowl
Saved as: SBStudentMedical2017

2017 NEVADA SCIENCE BOWL

HOSTED BY THE NATIONAL NUCLEAR SECURITY ADMINISTRATION, NEVADA FIELD OFFICE

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 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).

Print name of parent or legal guardian

Print name of student

Signature of parent or legal guardian: _____ Date: _____

NO FAX COPIES

RETURN BY REGISTRATION DEADLINE
NO FAX COPIES

Nevada Science Bowl
Saved as: SBStudentMedical2017