

**2013 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 7, 2012**.  
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	<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 7, 2012**  
**NO FAX COPIES**

Nevada Regional Science Bowl  
Saved as: SBStudentMedical2013

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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 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**