

# 2020 NEVADA SCIENCE BOWL

HOSTED BY THE NATIONAL NUCLEAR SECURITY ADMINISTRATION, NEVADA FIELD OFFICE

## Adult Confidential Medical Information and Emergency Notification Form

Must complete and sign in blue ink (preferred). Submit this form to regional 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: \_\_\_\_\_  
Please Include Area Code

### 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: \_\_\_\_\_

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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

*(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).

\_\_\_\_\_  
Print name

Signature in blue ink: \_\_\_\_\_ Date: \_\_\_\_\_

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