

# 2020 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). Submit this form to the coach; coach to submit 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

# 2020 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