U.S. DEPARTMENT OF ENERGY OFFICE OF SCIENCE
2025 National Science Bowl®
Student Confidential Medical Information Form
(Please fill out the entire 3-page form)

To complete: Click on the space and type in the information requested. Once the form is complete: (1) click "File," then "Save As" and give it a name and save it on your computer; (2) print the completed form; (3) parent/guardian or student (if 18) must sign it in ink or via Adobe Sign; (4) return this form to the coach.

School_____

Name _____ Birth Date _____ Sex: M ☐ F ☐

Street Address _____

City _____ State _____ Zip Code _____

Home Telephone (include area code): _____

PLEASE LIST TWO EMERGENCY CONTACTS:

	Primary Contact (#1)			**Contact #2**
Name:			**Name:**	
Phone:			**Phone:**	
Cell Phone:			**Cell Phone:**	
Relationship:			**Relationship:**	

Allergies

Yes	No		If Yes, specify:
☐	☐	Medication	_____
☐	☐	Food	_____
☐	☐	Environmental	_____

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)

_____

_____

_____

Medication Information (Prescribed and Over-the-Counter Medications and Purpose)
Please follow the format listed below.

Current Prescribed Medications – PLEASE PRINT!

Medication/Dosage	Purpose/Used For
(Example: Albuterol/10mg per day)	(Example: Asthma)

Current Over the Counter Medications – PLEASE PRINT!

Medication	Purpose/Used For
(Example: Advil/as needed)	(Example: Headaches)

Name _____

Physical Limitations/Needs (Please include any assistive devices that need to be provided):

Mobility Limitations _____

Visual Limitations _____

Communications Limitations _____

Dietary Restrictions (vegetarian, kosher, etc.): _____

If you have severe dietary restrictions, please list samples of meals that you CAN eat:

_____

_____

Religious or Cultural concerns that may affect care: (e.g. No Blood Transfusions) _____

_____

PHYSICIAN & HEALTH INSURANCE

Physician's Name: _____ **Phone Number:** _____

Do you have Health Insurance? YES ☐ **NO** ☐

If Yes, complete the following:

Insurance Company: _____

Policy Number: _____ **Phone Number:** _____