

**U.S. DEPARTMENT OF ENERGY OFFICE OF SCIENCE**

**2026 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:**

|                      | <b><u>Primary Contact (#1)</u></b> |  |                      | <b><u>Contact #2</u></b> |
|----------------------|------------------------------------|--|----------------------|--------------------------|
| <b>Name:</b>         |                                    |  | <b>Name:</b>         |                          |
| <b>Phone:</b>        |                                    |  | <b>Phone:</b>        |                          |
| <b>Cell Phone:</b>   |                                    |  | <b>Cell Phone:</b>   |                          |
| <b>Relationship:</b> |                                    |  | <b>Relationship:</b> |                          |

**Allergies**

Yes No

If Yes, specify:

\_\_\_\_ Medication \_\_\_\_\_

\_\_\_\_ Food \_\_\_\_\_

\_\_\_\_ Environmental \_\_\_\_\_

**Medical History (To include surgeries)**

Date of Last Tetanus Shot: \_\_\_\_\_

Name \_\_\_\_\_

(A) Current/Recent Medical History/surgery (within the past 12 months)

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(B) Previous Medical History/surgery (please include ALL medical history beyond 12 months)

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**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:** \_\_\_\_\_

**Name** \_\_\_\_\_