

**U.S. DEPARTMENT OF ENERGY  
2017 TENNESSEE SCIENCE BOWL**

**ADULT PARTICIPATION FORM**

Name: \_\_\_\_\_ School: \_\_\_\_\_

**1. MEDIA RELEASE:** To promote, evaluate, or otherwise describe the DOE's training and educational programs and activities, I give permission to the Department, its agents, ORAU, and the Oak Ridge Institute for Science and Education (ORISE) to photograph me and/or obtain interviews during the 2017 Tennessee on February 17-18, 2017 and to use in connection with any publication (including but not limited to brochures, booklets, videotapes, reports, press releases, Web sites, and exhibits) any image or recording in which I appear, to use and cite any comment(s), verbal or written, made by me about the program, and to use my name in connection with any publication and in such manner as determined by the DOE, ORAU, or ORISE.

**2. LIABILITY RELEASE:** I hereby release and discharge the DOE, ORAU, ORISE, the United States Government, their officers, agents, servants, and employees, and persons, firms, or corporations contracting with, or acting on behalf of, the DOE or the United States Government with respect to all activities associated with the DOE 2017 Tennessee Science Bowl competition, as well as their heirs, executors, administrators, successors, or assigns, from any cause of action of any nature whatsoever arising from my participation in any and all activities associated with the DOE 2017 Tennessee Science Bowl competition.

**ADULT CONFIDENTIAL MEDICAL INFORMATION AND EMERGENCY NOTIFICATION INFORMATION**

Chronic Medical Conditions: \_\_\_\_\_

Allergies (including food): \_\_\_\_\_

Current Medications: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Carrier Phone Number: \_\_\_\_\_

**3. MEDICAL TREATMENT AUTHORIZATION:** I hereby authorize and consent to the administration of all medical and/or surgical treatment(s) to me by a licensed physician, nurse or hospital in the event I am not able to consult with the attending physician(s), attempts to communicate with me or my emergency contact have been unsuccessful, and the attending physician(s) deem it advisable to proceed with such treatment(s).

**PLEASE SEND FORMS WITHIN 2 WEEKS OF COMPLETING YOUR ONLINE REGISTRATION.**

\_\_\_\_\_  
(Print Name of Adult) Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Adult) Date: \_\_\_\_\_