

HEALTH AND INJURY INFORMATION CARD and CONSENT FOR MEDICAL TREATMENT FORM

(This form is to be completed and kept available for reference whenever competition takes place.)

Student's Name _____

Age _____ Grade _____ Date of Birth _____ Today's Date _____

Parent's/Guardian's Name _____

Student's Address _____

Parent's/Guardian's Home Phone Number _____

Father's/Guardian's Place of Work _____

Father's/Guardian's Work Phone Number _____ Cell: _____

Mother's/Guardian's Place of Work _____

Mother's/Guardian's Work Phone Number _____ Cell: _____

In an emergency, when parent's/guardian's cannot be notified, please contact:

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

Family Physician _____ Phone _____

Preferred Hospital _____ Phone _____

Family Dentist _____ Phone _____

Insurance Provider _____ Policy # _____

Date of last tetanus booster: _____ (month/year)

Do you wear: Glasses yes ___ no / Contacts ___ yes ___ no / Dentures ___ yes ___ no

List any known allergies, drug reactions, or other pertinent medical information. (Diabetes, seizures, history of head injury with unconsciousness or confusion, medications, etc.)

Please note and date any new injury information here: _____

CONSENT FOR MEDICAL TREATMENT

Iowa law requires a parent's, or legal guardian's, written consent before their son or daughter can receive emergency treatment, unless, in the opinion of a physician, the treatment is necessary to prevent death or serious injury.

As the parent(s), or legal guardian(s), of the child named on the front of this card, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (we) understand that this written consent is given in advance of any specific diagnosis or hospital care. This written authorization is granted only after a reasonable effort has been made to contact me (us). I (we) further understand that I (we) will be responsible for all costs incurred and will not hold the school district liable.

_____ Date _____ Parent's/Guardian's signature

**Consent for Treatment endorsed by the Iowa Chapter of the American Academy of
Emergency Physicians.**

Cards provided by THE IOWA HIGH SCHOOL ATHLETIC ASSOCIATION, BOONE, IA