

# HEALTH AND INJURY INFORMATION CARD and CONSENT FOR MEDICAL TREATMENT FORM

*This form is to be completed and kept available for reference wherever competition takes place. Update medical information as necessary.*

Student's Name (Last, First, MI) \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Student ID# \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Student Address \_\_\_\_\_

Parent/Guardian Home Ph. Number(s) \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian Place(s) of Work \_\_\_\_\_

Parent/Guardian Work Phone Number(s) \_\_\_\_\_

In an emergency, when parent/guardian 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

- OVER PLEASE -

1203

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).*

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