

# 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 \_\_\_\_\_

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 \_\_\_\_\_

Mother's/Guardian's Place of Work \_\_\_\_\_

Mother's/Guardian's Work Phone Number \_\_\_\_\_

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 \_\_\_\_\_

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).*

\_\_\_\_\_  
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