HEALTH AND INJURY INFORMATION CARD and CONSENT FOR MEDICAL TREATMENT FORM(S)

(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 parents/guardians 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 (Emergency) 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).*

Parent's/Guardian's Signature Date

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

HIGH SCHOOL ATHLETES ONLY

CEDAR VALLEY MEDICAL SPECIALISTS PC

Consent for Treatment by Certified Athletic Trainer

I, _____ (name of parent/guardian) authorize the routine care and treatment as may be deemed necessary and advisable in the diagnosis of _____(name of minor child) as provided by the Cedar Valley Medical Specialist Certified Athletic Trainers. I understand that I will receive protected health information (PHI) directly relevant to, and for the purposes of my involvement in the child's care. PHI will be given as dictated by State law.

I hereby indemnify and hold harmless medical provider and their officers, agents, employees, contractors, attorneys, directors, insurers, affiliates, subsidiaries, and related corporations from all liability for acting in reliance of this authorization.
This authorization is valid for **one (1) year** from the date of the signature below. This authorization can be terminated in writing prior to the expiration date if received in writing to the Athletic Trainer at either Waterloo East High or Waterloo West High.

BY SIGNING BELOW, I ATTEST THAT I HAVE READ THE ABOVE CONSENT AND AGREE TO ITS TERMS

Parent/Guardian Signature Date

Parent/Guardian Printed Name