

2012 - 2013 SCHOOL YEAR  
ALBURNETT COMMUNITY SCHOOLS

**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) \_\_\_\_\_

Grade \_\_\_\_\_ Age \_\_\_\_\_ 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 Name \_\_\_\_\_ Cell Number \_\_\_\_\_

Father's/Guardian's Place of Work \_\_\_\_\_ Work Number \_\_\_\_\_

Mother's/Guardian's Name \_\_\_\_\_ Cell Number \_\_\_\_\_

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

Does this athlete wear: Glasses \_\_\_\_\_ yes \_\_\_\_\_ no / Contacts \_\_\_\_\_ yes \_\_\_\_\_ no

Retainers \_\_\_\_\_ yes \_\_\_\_\_ no / Dentures \_\_\_\_\_ yes \_\_\_\_\_ no

List any known allergies, drug reactions, or other pertinent medical information:

\*Asthma (inhaler), 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