HEALTH AND INJURY INFORMATION AND CONSENT FOR MEDICAL TREATMENT FORM
KEOTA SCHOOLS

This form is to be completed and kept available for reference wherever competition takes place.

Student's Name (Last, first, MI) ________________________________ Today's date ____________
Age _____ Grade _____ Date of Birth __________ Social Security Number ______________________
Parent's/Guardian's Name ____
Student's Address ____
Parent's/Guardian's Home Phone Number________________ Cell Phone Number_______________
Father's/Guardian's Place of work ____
Mother's/Guardian's Place of work____
Father's/Guardian's work phone # _____________ Mother's/Guardian's work phone #_____________
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.)

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Please note and date any new injury information here:
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CONSENT FOR MEDICAL TREATMENT

Iowa law required a parent's or legal guardian's written consent before their child 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 at the beginning of this form, 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____________ Signature____

Consent to Treatment endorsed by the Iowa Chapter of the American Academy of Emergency Physicians

Insurance Policy Holder's Name ____
Social Security Number ______________ Date of Birth ________________
Insurance Company ____
Policy Number ____
(Please attach a copy of the insurance card if at all possible)
If the parents or guardians are not available for consultation with the medical staff, please contact:
Name:____ Phone number:______________________
Address: _____________________________________ Cell phone number ___________________