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.)

Please note and date any new injury information here:

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 _____