## 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

# CONSENT FOR MEDICAL TREATMENT

The Knoxville Community School District has contracted with 21st Century Rehab, P.C. to provide medical coverage for your son or daughter's athletic teams. 21st Century Rehab, P.C. requires a written consent in addition to the medical card consent that is provided by the Iowa High School Association to provide medical care to your child.

I (we) understand that this written consent gives 21st Century Rehab,P.C. personnel the right to evaluate and treat my son or daughter in situations where medical attention is necessary. 21st Century Rehab, P.C. personnel will only perform medical actions that fall within the scope of practice of each individual's medical license. I further consent the release of medical information to and from the athlete's primary physician, 21st Century Rehab staff member, and coach.

As the parent(s), or legal guardian(s) of ______________________________ I authorize
Child's name
21st Century Rehab, P.C. personnel to: evaluate and treat acute injuries and if necessary to communicate with the active physician and coach of injuries sustained by my son or daughter. If further advanced medical attention is needed, the parents and physician will be notified.

______________ ______________________________________________

Date Parent's/Guardian's signature

It is also required to have written permission for 21st Century Rehabilitation to administer or carry any medication (such as an albuterol inhaler, etc) your child may need. If your son/daughter has a prescription, or an over the counter medication that you wish 21st Century Rehabilitation to carry in our medical kit or administer to your child please list the medication and dosage below, as well as your signature.

________________________________________________________________

________________________________________________________________

________________________________________________________________

______________ ______________________________________________

Date Parent's/Guardian's Signature