

**HEALTH AND INJURY INFORMATION FORM and CONSENT FOR MEDICAL TREATMENT**

Student's Name (Last, First, MI) \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Student's Address \_\_\_\_\_

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

Mother's/Guardian's Place of Work \_\_\_\_\_ Phone Number \_\_\_\_\_

In an emergency, when parent's/guardian's cannot be notified, please contact:  
\_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Preferred Hospital \_\_\_\_\_ Phone Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Date of last tetanus booster: \_\_\_\_\_ (month/year) Glasses? \_\_\_\_\_ Contacts? \_\_\_\_\_ Dentures? \_\_\_\_\_

**-OVER PLEASE-**

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**-OVER PLEASE-**

List any known allergies, drug reactions, injuries, or other pertinent medical information. \_\_\_\_\_

DIETARY REQUIREMENT: Please list any special dietary requirements. \_\_\_\_\_

**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**

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