JACKSON COUNTY
REGIONAL HEALTH CENTER
GENESIS HEALTH SYSTEM

Maquoketa High School

Health & Injury Information & Consent for Medical Treatment

This form is to be kept available for reference when a practice/competition takes place. Update medical information when necessary.

Athlete's Name_____
Age___ Grade___ Date of Birth_____
Address_____
Parent/Guardian Name(s)_____
Daytime Phone # (reach in emergency)_____
Evening Phone # (reach in emergency)_____
Preferred Hospital_____
Student currently taking medication? _____ If so, what?_____
Allergies to Medication_____
Student been prescribed inhaler or Epi-Pen?_____
List any health problems_____
(diabetes, asthma, seizures, depression, ADHD, heart problems, head injuries)
List all injuries resulting in loss of playing
time_____
List any known allergies or other pertinent medical
information_____

I (we) are aware that with the participation in sports comes the risk of injury. I (we) understand that such a risk is inherent in play and practice for all sporting activities.

****Date_____ Parent/Guardian's Signature_____**

Consent for Emergency Medical Treatment

Iowa law requires a parent's, or legal guardian's written consent before their son/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 above, 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 this written consent is given in advance of any specific diagnosis or hospital care. I understand it is my (our) responsibility to cover any and all costs occurred related to accident or illness; including transportation, doctor visits, tests, treatment, etc. This written authorization is granted only after a reasonable effort has been made to contact me (us).

As the parent(s), or legal guardian(s), of the child named above, I (we) authorize medical treatment and rehabilitation care that is necessary in the event of an injury to my (our) child. Treatment may include heat, ice, and/or exercises to name a few.

I (we) hereby authorize Jackson County Regional Health Center (JCRHC), its agents, and employees, as providers of athletic training services to Maquoketa School District Board of Education (School), to release information to the School and its agents and employees regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's training for and participation in athletics at School. I (we) understand that, in order to participate in interscholastic sports, it is imperative that JCRHC is able to disclose my protected health information to individuals such as a coach, athletic director, or school official, as well as to other health care providers, hospitals and/or medical clinics and laboratories, and I hereby consent to any such disclosure. I (we) acknowledge that this protected health information may be protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) and may concern medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. I (we) further acknowledge that the information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

****Date_____ Parent/Guardian's Signature_____**

PLEASE NOTE: THIS FORM IS NOT COMPLETE WITHOUT PARENT/GUARDIAN'S SIGNATURE.