

**Mason City Community School District**

**STUDENT EMERGENCY TREATMENT RELEASE**

**STUDENT'S NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**PARENT/GUARDIAN NAME:** \_\_\_\_\_

**PARENT/GUARDIAN PLACE OF WORK:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**PERSON TO BE NOTIFIED OTHER THAN PARENT/GUARDIAN IN EMERGENCY:**

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**FAMILY PHYSICIAN:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**FAMILY DENTIST:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**DATE OF LAST TETANUS BOOSTER:** \_\_\_\_\_ (MONTH/YEAR)

**ALLERGIES (LIST ANY KNOWN ALLERGIES, DRUG REACTIONS, ETC):**

\_\_\_\_\_

**STUDENT EMERGENCY TREATMENT RELEASE**

**PERTINENT MEDICAL INFORMATION (DIABETES, SEIZURES, HISTORY OF HEAD INJURY, ETC.):**

\_\_\_\_\_

**MEDICAL ALERT ID WORN: YES OR NO IF YES, WHAT TYPE:** \_\_\_\_\_

**MEDICATIONS TAKEN REGULARLY:** \_\_\_\_\_

**PLEASE CIRCLE IF WORN: GLASSES CONTACTS DENTURES**

**SPECIAL INSTRUCTIONS:** \_\_\_\_\_

**HEALTH INSURANCE:** \_\_\_\_\_ **POLICY #:** \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT:** IOWA LAW REQUIRES A PARENT'S/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/LEGAL GUARDIAN OF THE CHILD NAMED ON THE FRONT OF THIS CARD, I AUTHORIZE EMERGENCY MEDICAL TREATMENT OR HOSPITALIZATION THAT IS NECESSARY IN THE EVENT OF AN ACCIDENT OR ILLNESS OF MY CHILD. I 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.

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_