Medical Information - Emergency Release

Club Name ______________________

Participant's Name ______________________

Permanent Address ______________________

City, State, Zip ______________________

ISU Card # ______________________

Date of Birth ______________ Gender ________

Home Phone ______________________

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First

Name ______________________

Relation to Participant ______________________

Daytime Phone ______________________

Evening Phone ______________________

Name of Family Doctor ______________________

Name of Dentist ______________________

Backup Contact (Relative or Friend)

Name ______________________

Relation to Participant ______________________

Daytime Phone ______________________

Evening Phone ______________________

Office Number ______________________

Office Number ______________________

INSURANCE POLICY INFORMATION

The above-named participant is covered by health insurance. ☐ Yes** ☐ No*

* If no, initial this line stating that you do not have health insurance and are aware that ISU and the ISU Club named above does **not** carry any health insurance for you. ____________

** If yes, provide the following information which is required by Iowa State University to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name ______________________ P.H.'s Date of Birth ______________

Address ______________________ Relation to Participant ______________

City, State, Zip ______________________ Occupation ______________

P.H.'s Employer's Name/Address ______________________

____

Insurance Company Name ______________________

Policy # ______________________ Plan # ______________

Health Information *(Please Print)*

Do you have any of the following conditions or a history of any of the following conditions? (***Check all that apply***.)

☐ Asthma
☐ Diabetes
☐ Convulsions/seizure
☐ Migraine headaches
☐ Other condition(s): (Please list)______________________
☐ Bronchitis
☐ Ear Infections
☐ Hay Fever
☐ Fainting Spells
☐ Heart or cardio-vascular problems/disease
☐ Chronic bone, muscle or joint injuries

Allergies or reactions: (***Check all that apply.***)

☐ Aspirin ☐ Penicillin ☐ Other (list) ______________________

Date of last tetanus shot (*approximate if necessary*):______________________

Are you currently on any prescribed or over-the counter medication? (If so, please record the condition/ailment, name of medication, dosage, time(s) of day, prescribing physician.) ______________________

TO BE READ AND SIGNED BY PARTICIPANT

MEDICAL EMERGENCY PERMISSION*

The health history is correct and complete to my knowledge. If an injury or other medical condition occurs or arises, I hereby give permission to the ISU Club coordinator or volunteers to provide routine health care and seek emergency treatment including x-rays or routine tests. I agree to the release of any record necessary for treatment, referral, billing or insurance purposes. I understand that I am financially responsible for charges and hereby guarantee full payment to the attending physicians or health care unit. In the event of an emergency where I cannot decide for myself, I give permission to the physician/hospital selected by the ISU Club coordinators or volunteer to secure and administer treatment for me, including hospitalization. (*If you cannot sign this section of the form for any reason, contact the ISU Risk Management regarding a legal waiver in order to attend and participate.)

______________ Date

______________________ Name (please print)

______________________ Signature

______________________ Signature of Parent or Guardian (if under 18)