GOOD CONDUCT and
CONSENT FOR MEDICAL TREATMENT FORM

(This form is to be completed and kept available for reference use wherever competition takes place. Update medical information as necessary.)

GOOD CONDUCT POLICY

All students participating in extra-curricular and co-curricular activities serve as ambassadors of ELC throughout the 12-month calendar year, whether away from school or at school. Students who wish to exercise the privilege of participating in these activities must conduct themselves in accordance with the Estherville Lincoln Central Good Conduct Policy. This policy is located in the Student Handbook. I have read and understand this and all information as stated in the ELC Good Conduct Policy.

_____ _____
Signature of student **Today's date**

_____ _____
Signature of parent or legal guardian **Today's date**

Parent/Guardian Name_____
Parent/Guardian Phone Numbers_____

In an emergency when the parents/guardians cannot be notified, please contact:
1. _____ **Relationship** _____**Phone** _____

2. _____ **Relationship** _____**Phone** _____

Family Physician _____**Phone** _____

Preferred Hospital _____**Phone** _____

Family Dentist _____**Phone** _____
Date of last tetanus booster: _____ **(month/year)**

Are glasses worn? ___yes ___no Contact lenses? __yes ___ no Dentures?___yes ___no

Please list any known allergies, drug reactions, or any other pertinent medical information. (*Diabetes, seizures, history of head injury with unconsciousness and/or confusion, medications taken regularly,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.
This form provided by
THE IOWA HIGH SCHOOL ATHLETIC ASSOCIATION, BOONE IA.