**INDIANOLA COMMUNITY SCHOOL DISTRICT**
**ATHLETE MEDICAL EMERGENCY AND HEALTH HISTORY**

Student's Name:_____ Age:_____ Grade:____ Date of Birth:_____
Parent/Guardian Name(s):_____ Address:_____
Parent/Guardian Home Ph. #:_____ Cell:_____
Parent/Guardian Place(s) of Work:_____
Parent/Guardian Work Phone #: _____
In an emergency, when a parent/guardian cannot be notified, please contact:
_____ Relationship_____ Ph. #:_____
_____ Relationship _____ Ph. #:_____
Family Physician:_____ Phone #: _____ Preferred Hospital_____
Family Dentist: _____ Phone #: _____

**HEALTH HISTORY**
Date of last Tetanus Booster:_____ (month/year) Dentures ____yes _____no
Do you wear glasses? ____yes ___no/ contacts ____yes ____no
Known Allergies? ____yes ____no if yes, please list:_____
Diabetes ___yes ___no if yes, list type and medication form _____
Asthma ___yes ___no if yes medications:_____ Do you use an inhaler? __yes ____no
Do you or ever have experienced seizures? ___yes ____no

**INJURY HISTORY**
Have you had to be transported to a medical facility for dehydration? ____ yes ____no
If yes, what facility and when (month/year):_____
Have you ever had surgery for damaged bones, ligaments, tendons or fractures? ___yes ____no
If yes, please describe the body part, the injury, the surgery and the month/year:
_____
Have you ever been diagnosed by a medical professional for a sports related head injury? ___yes ___no
If yes, please list the doctor, the medical facility, the diagnosis, any tests that were done and the month/year of the incident. Any head injuries diagnosed by a medical professional must be recorded on our files in the Indianola Athletic Department.
_____
_____
_____

**INSURANCE INFORMATION**
All participants in athletics must have some type of family health/accident insurance coverage or must purchase an alternate school policy.

1. ___ My child is covered by a family health/accident insurance plan
   Insurance Company:_____ Policy Number/ID:_____
   Policy Holder's Name:_____ and Date of Birth:_____
2. ___ I will purchase the alternate health/accident policy available through the Indianola Community School.

**Authorization to Provide Medical Attention**
By signing below I give my permission to an authorized school official to obtain medical attention for my child in case of injury or illness and have filled out the above information to the best of my knowledge.

_____ _____ _____
Signature of the Parent/Guardian Signature of the Student-Athlete Date