

## Iowa County Conservation Health and Consent Form - For Emergency Treatment

Participant's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_

Street address/Apartment number/PO Box City Zip

Primary Contact In Case of Emergency: Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_

Relationship to Participant: Parent \_\_\_\_\_ Guardian \_\_\_\_\_ Other \_\_\_\_\_

Secondary Contact In Case of Emergency:

\_\_\_\_\_

Phone: (Cell ) \_\_\_\_\_ (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Family Physician or

Clinic \_\_\_\_\_ Phone \_\_\_\_\_

Social Security Number (Required by Hospital Emergency) \_\_\_\_\_

List below any physical conditions that the ICC staff should know (this is confidential to ICC staff):

Medications (name, dose, time, reason) \_\_\_\_\_

Allergies (explain) \_\_\_\_\_

Allergic to any drug? \_\_\_\_\_

Any limiting physical conditions \_\_\_\_\_

Any special dietary needs \_\_\_\_\_

Any additional information we should know \_\_\_\_\_

\_\_\_\_\_

I understand that first aid will be available, that the members will be closely supervised and that if a serious illness or injury develops, medical and/or hospital care will be given. However, the ICC staff is not responsible in case of accidental injury or illness. I further understand that in case of serious injury or illness, we will be notified, but if it is impossible to contact us, we give permission for emergency treatment or surgery as recommended by attending physician.

Signature of Parent or Guardian \_\_\_\_\_

I give Iowa County Conservation staff permission to photograph my child for publicity purposes:

Yes \_\_\_ No \_\_\_