

**LAKE COUNTRY LUTHERAN HIGH SCHOOL**

**AGREEMENT FOR MEDICAL TREATMENT OF INJURED STUDENTS**  
**and**  
**STUDENT INSURANCE STATEMENT**

First aid to an injured student shall be administered by a representative of the school unless a physician, emergency medical technician, or certified trainer is in attendance at the time of the injury; in the latter case, the physician, emergency medical technician, or certified trainer will render first aid.

If the injury is one which appears to be serious, the injured student will be conveyed by ambulance, if available, to a doctor, clinic, or hospital for treatment.

The parents of a student who incurs an injury which requires more than first aid will be notified as soon as practical after the injury occurs. In an emergency, this notification may not occur until after the injured student has been conveyed from the scene to a doctor, clinic, or hospital for treatment.

**PLEASE USE A BLACK PEN**

STUDENT \_\_\_\_\_  
(print FULL name)

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

We have read and understand the procedure described above for the treatment of injured students participating in activities sponsored by LCLHS. We consent to having our son/daughter participate in appropriate activities sponsored by LCLHS under these conditions and authorize the treatment of injuries incurred by our child according to the procedure described.

We understand that the Lutheran High School Association does not carry medical expense insurance for the benefit of any student who may be injured while participating in activities and that the Lutheran High School Association assumes no responsibility for such medical expense. We further understand that a student will not be allowed to participate in sponsored activities without insurance coverage under their parent's insurance plan or another acceptable means.

My son/daughter is covered by our insurance with:

\_\_\_\_\_ Insurance Company

\_\_\_\_\_ Policy number

Hospital Preference: \_\_\_\_\_

Family Doctor \_\_\_\_\_

Family Dentist \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Emergency Phone Number: \_\_\_\_\_

Father: \_\_\_\_\_  
(print FULL name)

Mother: \_\_\_\_\_  
(print FULL name)

SIGNATURES: Father: \_\_\_\_\_ Date: \_\_\_\_\_

and/or Mother: \_\_\_\_\_ Date: \_\_\_\_\_

Student: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE USE **BLACK PEN!**

Date \_\_\_\_\_

**A. Past Medical History**

1. Any operations? (what?, when?) \_\_\_\_\_  
\_\_\_\_\_
2. Hospitalized for any reason? (why?, when?) \_\_\_\_\_  
\_\_\_\_\_
3. Visit to a doctor in past year? (why? when?) \_\_\_\_\_  
\_\_\_\_\_
4. Any allergies? (To what? Type of reaction?) \_\_\_\_\_  
\_\_\_\_\_
5. Any medications at present? (what? dose?) \_\_\_\_\_  
\_\_\_\_\_
6. Is immunization record complete? \_\_\_\_\_

Give dates if not up to date. Tetanus \_\_\_\_\_ Polio \_\_\_\_\_ Mumps \_\_\_\_\_  
Measles \_\_\_\_\_ Rubella \_\_\_\_\_ Diptheria \_\_\_\_\_ Hep. B \_\_\_\_\_ Chicken Pox? \_\_\_\_\_

**B. Injury Record**

	Yes	No	Date	See an MD?	Activity Curtailed?	Hospitalized?
1. Concussion Knocked out						
2. Other head injury						
3. Neck injury						
4. Abdominal injury						
5. Heat illness						

	Yes	No	Right	Left	Date
6. Shoulder dislocation					
7. Shoulder seperation					
8. Knee injury including water on the knee					
9. Ankle injuries (twists, sprains)					
10. Fractures (Broken bones)					
11. Other musculoskeletal (dislocation, sprain)					
12. Other					

**C. Review of Systems - Have you ever had? (check those that apply)**

- |                              |                                     |
|------------------------------|-------------------------------------|
| 1. Irregular pulse _____     | 9. Enlarged liver or jaundice _____ |
| 2. Heart disease _____       | 10. Kidney Disease _____            |
| 3. High Blood Pressure _____ | 11. Seizures _____                  |
| 4. Collapsed Lung _____      | 12. Hernia _____                    |
| 5. Asthma _____              | 13. Retinal injury _____            |
| 6. Tuberculosis _____        | 14. Single eye _____                |
| 7. Enlarged Spleen _____     | 15. Thyroid Disease _____           |

D. Do you wear contact lenses for sports? YES NO