USA HOCKEY

CONSENT TO TREAT

This is to certify that on this date, I _____, as parent or guardian of _____ (athlete participant), or for myself as an adult participant, give my consent to USA Hockey and its medical representative to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury that could arise from participation in USA Hockey sanctioned events.

If said participant is covered by any insurance company, please complete the following:

Name of Insurance Company: _____

Address: _____

Policy Number: _____

Signed: _____

(parent/guardian or adult participant)

Relationship to Athlete: _____

Home Address: _____

Phone: (_____)_____ Date: _____

Excess accident insurance up to $25,000, subject to deductibles, exclusions and certain limitations, is provided to all USA Hockey registered team participants. For further details visit www.usahockey.com or call USA Hockey at 719-576-USAH.

MEDICAL HISTORY FORM

(COMPLETION OF THIS SIDE OF THE FORM IS OPTIONAL)

Name _____ Date: _____

Address: _____ Birthdate: _____

_____

Daytime Phone: _____ Evening Phone: _____

WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Physician's Name: _____

Daytime Phone: _____ Evening Phone: _____

Hospital of Choice: _____

PLEASE COMPLETE THE FOLLOWING:

If the answer to any of the following questions is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have you had (or do you presently have) any of the following?	**Circle One**	
Head injury (concussion, skull fracture)	Yes	No
Fainting spells	Yes	No
Convulsions/epilepsy	Yes	No
Neck or back injury	Yes	No
Asthma	Yes	No
High blood pressure	Yes	No
Kidney problems	Yes	No
Hernia	Yes	No
Diabetes	Yes	No
Heart murmur	Yes	No
Allergies	Yes	No
Please specify: _____		

Injuries to:

Shoulder	Yes	No
Knee	Yes	No
Ankle	Yes	No
Fingers	Yes	No
Arm	Yes	No
Other: _____		
Impaired vision	Yes	No
Impaired hearing	Yes	No
Other: _____		

Have you had a recent tetanus booster? _____ If so, when? _____

Are you currently taking any medications? _____ What? Why? _____

_____

Has the doctor placed any restrictions on your activity? _____ Explain: _____

_____