USA HOCKEY

CONSENT TO TREAT

This is to certify that on this date, I ___________________________, as parent or guardian of _____________________________, 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 athlete, for any injury that could arise from participation in USA Hockey sanctioned events.

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

Name of Insurance Company: ____

Address: ____

Policy Number: ____

Signed: ____
(parent/guardian)

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 call Jay Bernard at 1-800-486-6880.

(over, please)

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:** ______________________________

____

Signed: ______________________________ Date: ____________
(Athlete)

Signed: ______________________________ Date: ____________
(Parent)