

USA HOCKEY CONSENT TO TREAT

FOR OFFICE USE ONLY

| | |
|--------------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Paid Player | <input type="checkbox"/> Paid Coach |
| <input type="checkbox"/> Previously-Registered # _____ | |
| <input type="checkbox"/> Paid Cash | <input type="checkbox"/> Check # _____ |
| <input type="checkbox"/> Credit Card | |
| Received on _____ | |
| Received by _____ | |

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 of Insurance Company: _____

Policy Number: _____

Signed: _____

(Parent/Guardian)

Date: _____ Relationship to Athlete: _____

Home Address: _____

Telephone (H): _____ (W): _____ (C): _____

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.

(see reverse side for Medical History Form)

MEDICAL HISTORY FORM
(Completion of this side of the Form is optional)

Name: _____ Date: _____
Address: _____ Birth Date: _____

Cell Phone: _____
Daytime Phone: _____ Evening Phone: _____

WHOM 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**, on a separate sheet of paper, please describe the problem and its implications for proper first aid treatment.

Have you had (or do you presently have) any of the following?

Check One

- | | | |
|------------------------------------------------|------------------------------|-----------------------------|
| Head injury (concussion, skull fracture, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fainting spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Convulsions/epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neck or back injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please specify: _____

Injuries to:

- | | | |
|----------|------------------------------|-----------------------------|
| Shoulder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Knee | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ankle | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fingers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arm | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other: _____

Have you had a recent tetanus booster? Yes No If yes, when? _____

Are you currently taking any medications? Yes No
If yes, What? _____ Why? _____

Has the doctor placed any restrictions on your activity? Yes No
If yes, explain: _____

Signed: _____ Date: _____
(Athlete)

Signed: _____ Date: _____
(Parent/Guardian)