



Player Level: \_\_\_\_\_

Player Name: \_\_\_\_\_

# 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 activities.

(parent or guardian)

(athlete)

USA Hockey provides excess accident coverage with a \$250 deductible with no other “collectable” insurance and \$100 deductible with other “collectable” insurance.

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

Name of Carrier \_\_\_\_\_

Address \_\_\_\_\_

Policy Number \_\_\_\_\_

Signed \_\_\_\_\_

Relationship to athlete \_\_\_\_\_

Home Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Phone(s): Day \_\_\_\_\_ Evening \_\_\_\_\_

## WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name: \_\_\_\_\_ Phone(s): \_\_\_\_\_

Relationship: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone(s): \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_

**PLEASE ANSWER 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 the back.)

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

Specify: \_\_\_\_\_

Injuries to:

Shoulder	YES	NO
Knee	YES	NO
Ankle	YES	NO
Fingers	YES	NO
Arm	YES	NO
Other _____	YES	NO

Poor vision YES NO

Poor hearing YES NO

Other: \_\_\_\_\_

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

Are you currently taking any medication? What? Why? \_\_\_\_\_

Has the doctor placed any restrictions on your activity? Explain. \_\_\_\_\_

Signed: \_\_\_\_\_

(athlete)

(parent or guardian)