HOPKINS YOUTH HOCKEY ASSOCIATION
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: (If blank, please list Name of Insurance Company and Policy Number.)

Insurance Company and Policy Number: ____

Signed (Parent or Guardian): ____ Date: ____________

Excess accident insurance up to $25,000, subject to deductibles, exclusions and certain limitations, is proviced to all USA Hockey registered team participants. For further details, call Jay Bernard at 1-800-486-6880.

MEDICAL HISTORY

Name: ____ **Birth Date:** ____________________________

Address: ____ **Daytime Phone:** ________________________

____ **Evening Phone:** ________________________

____ **Cell 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 yes, please describe below the problem and its implications for proper first aid treatment. Have you had or currently 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: ________________________		

	Circle One	
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 (Athlete): ____ Date: ____________

Signed (Parent): ____ Date: ____________

2010 -2011 Season