



MEDICAL CONSENT TO TREAT FORM

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 Breezy Point Sports Inc., Breezy Point Hockey Academy, and Breezy Point Acceleration Training Center, and its medical representative(s) to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury or illness that could arise from participation in any Breezy Point Hockey Academy events and activities. I give consent for the above mentioned athlete to be transported either by Breezy Point Hockey Academy staff or by ambulance to obtain medical care. I certify that the above mentioned athlete is in good health, and can participate without restriction in the Breezy Point Hockey Academy's training, events, and activities. I release Breezy Point Sports Inc., Breezy Point Hockey academy, Breezy Point Acceleration Training Center of any liability arising from any treatment or transportation provided in any event requiring medical treatment.

Signed: _____ Date: _____
(Parent/Guardian or Adult Participant)

Relationship to Athlete: _____

Home Address: _____

Phone: (____) _____ Cell Phone: (____) _____

*Do you consent to Tylenol or Ibuprofen being administered to the above mentioned athlete if deemed necessary for the relief of minor aches and pains. **Yes:** ____ **No:** ____ **Initial:** _____

Insurance company, please complete the following:

Name of Health Insurance Company: _____

Address: _____

Policy Number: _____

- **Must send a copy of Health Insurance Card, both sides.**



MEDICAL HISTORY INFORMATION EMERGENCY CONTACT INFORMATION

Athlete Name _____ Date: _____

Address: _____ Date of Birth _____

Daytime Phone: _____ Evening Phone: _____

WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PLEASE COMPLETE THE FOLLOWING:

If the answer to any of the following questions is or was yes, please describe the problem and any 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 shot? Yes No: If so, when? _____

Are you currently taking any medications? Yes No: If so, Explain: _____

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