

MEDICAL HISTORY FORM

Players Last Name:	First Name:	M.I.		
Address:	City:	State:	Zip:	
Date of Birth:	Current Age:	Male:	Female:	

WHO TO CONTACT IN CASE OF AN EMERGENCY

Emergency Contact:		Relationship to Player:
Home Phone:	Work Phone:	Cell Phone:
Physicians Name	Phone:	Hospital of Choice:

PLEASE ANSWER THE FOLLOWING:

(If any answers are yes, describe the problem and its implications for proper first aid treatment on the back of this form.)

Asthma	YES	NO	Allergies	YES	NO
Autistic	YES	NO	Specify: _____		
Diabetes	YES	NO	_____		
Down syndrome	YES	NO	_____		
Epilepsy	YES	NO	Injuries to	YES	NO
Fainting spells	YES	NO	Shoulder	YES	NO
Head injury (concussion, skull fracture)	YES	NO	Knee	YES	NO
Hearing Impaired	YES	NO	Ankle	YES	NO
Heart murmur	YES	NO	Fingers	YES	NO
Hernia	YES	NO	Arm	YES	NO
High blood pressure	YES	NO	Other _____		
Kidney problems	YES	NO	_____		
Neck or back injury	YES	NO			
Seizures/Convulsions	YES	NO			
Vision Impaired	YES	NO			
	YES	NO			

Have you had a recent tetanus booster? YES NO If so, when? _____

Are you currently taking any medication? YES NO Why? _____

What? _____

Has the doctor placed any restrictions on your activity? Explain _____

This is to certify that on this date, I _____, as a 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.

PRINT PLAYERS NAME

PARENT, GUARDIAN OR PLAYER (+18) SIGNATURE

DATE