

USA Hockey Consent To Treat/Medical History Form



This is to certify that on this date, I		, as parer	nt or
guardian of	, (athl	lete participant), or for myself a	s an
adult participant, give my consent t	o USA Hockey and its medic	cal representative to obtain med	dical
care from any licensed physician, ho	spital, or clinic for the above	mentioned participant, for any ir	njury
that could arise from participation in	USA Hockey sanctioned eve	ents.	
If said participant is covered by any	insurance company, please	complete the following:	
Insurance Company:			
Policy Number:			
Parent/Guardian/Adult Participant Signature:		Date:	
Excess accident insurance up to \$2 is provided to all USA Hockey regist contact USA Hockey at (719) 576-U	ered team participants. For fu		
COMPLETION OF MEDIC	CAL HISTORY INFORMATIO	N BELOW IS OPTIONAL	
EMERGENCY CONTACT			
Name:		Phone:	
Address:			
Physician's Name:		Phone:	
Hospital of Choice:			
MEDICAL HISTORY If the answer to any of the following for proper first aid treatment on the		ribe the problem and its implicat	tions
☐ Head Injury	☐ Asthma	☐ Allergies	
(concussion, skull fracture)	☐ High blood pressure	☐ Diabetes	
Fainting spellsConvulsions/epilepsy	Kidney problemsHernia	Other	
☐ Neck or back injury	☐ Heart murmur		
Have you had (or do you currently Have you had a recent tetanus boos Are you currently taking any medical Has a doctor placed any restrictions.	ter? Yes No If yes, tions? Yes No If yes,	when?	ıck.