USA Hockey
Consent To Treat/Medical History 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 USA Hockey and its medical representative to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury that could arise from participation in USA Hockey sanctioned events.

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 $50,000, subject to deductibles, exclusions and certain limitations, is provided to all USA Hockey registered team participants. For further details visit usahockey.com or contact USA Hockey at (719) 576-USAH.

EMERGENCY CONTACT

Name: _____ Phone: _____

Address: _____

Physician's Name: _____ Phone: _____

Hospital of Choice: _____

COMPLETION OF MEDICAL HISTORY INFORMATION BELOW IS OPTIONAL

MEDICAL HISTORY

If the answer to any of the following questions is yes, please describe the problem and its implications for proper first aid treatment on the back of this form.

- ❑ Head Injury *(concussion, skull fracture)*
- ❑ Fainting spells
- ❑ Convulsions/epilepsy
- ❑ Neck or back injury
- ❑ Asthma
- ❑ High blood pressure
- ❑ Kidney problems
- ❑ Hernia
- ❑ Heart murmur
- ❑ Allergies _____
- ❑ Diabetes
- ❑ Other _____

_____

_____

Have you had (or do you currently have) any of the following?

Have you had a recent tetanus booster? ❑ Yes ❑ No If yes, when? _____

Are you currently taking any medications? ❑ Yes ❑ No If yes, please list all medications on back.

Has a doctor placed any restrictions on your activity? ❑ Yes ❑ No If yes, please explain on back.