CENTRAL CATHOLIC VIKINGS HOCKEY

Consent to Treat * Consent to Transport * Medical History

Please print legibly or type and sign where indicated. Please complete entire form.

CONSENT TO TREAT

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 Central Catholic Vikings Hockey Club ("CCVHC") coaching staff and board of directors to obtain emergency medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury that could arise from participation in CCVHC sanctioned events and/or activities.

Insurance Company: _____

Subscriber's Name (on insurance card): _____

Policy Number: _____*Phone Number:* _____

Parent/Guardian/Adult Participant Signature: _____Date _____

CONSENT TO TRANSPORT

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 Central Catholic Vikings Hockey Club ("CCVHC") coaching staff and board of directors to transport the above mentioned participant to obtain emergency medical care from any licensed physician, hospital, or clinic, for any injury that could arise from participation in CCVHC sanctioned events and/or activities.

Parent/Guardian/Adult Participant Signature: _____Date _____

EMERGENCY CONTACT INFORMATION

Please provide emergency contact information for the above mentioned participant. In addition to parent(s), please provide one additional person who may be contacted in the event that CCVHC is unable to reach the parent(s). Please print or type.

Name: _____Phone:_____

Address: _____

Relationship to Participant: _____

Name: _____Phone:_____

Address: _____

Relationship to Participant: _____

Name: _____Phone:_____

Address: _____

Relationship to Participant: _____

Physician's Name & Contact Information

Physician's Name: _____

Phone: _____

Hospital of Choice: _____

MEDICAL HISTORY *(completion of this section is optional)*

If the answer to any of the following questions is **yes**, please describe the problem and its implications for proper first aid treatment below. Please print or type.

❑ Head Injury *(concussion/fracture)*	❑ Neck or back injury	❑ Asthma	❑ Allergies
❑ Convulsions/epilepsy	❑ Fainting spells	❑ Kidney problems	❑ Hernia
❑ High blood pressure	❑ Heart murmur	❑ 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 below or attach.

Has a doctor placed any restrictions on your activity? ❑ Yes ❑ No If YES, please explain below or attach.

_____

_____

_____

_____