



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 \$25,000, 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: _____

Telephone: _____

Address: _____

Physician's Name: _____

Telephone: _____

Choice of Hospital: _____

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.

- | | | |
|---|--|--|
| <input type="checkbox"/> Head Injury (concussion, skull fracture) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Kidney problems | _____ |
| <input type="checkbox"/> Convulsions/epilepsy | <input type="checkbox"/> Hernia | _____ |
| <input type="checkbox"/> Neck or back injury | <input type="checkbox"/> Heart murmur | |

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

- | | |
|--|---|
| Have you had a recent tetanus booster? | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ |
| Are you currently taking any medications? | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list all medications on back. |
| Has a doctor placed any restrictions on your activity? | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain on back. |