



USA HOCKEY CONSENT TO TREAT

This is to certify that on this date, I _____,
(parent or guardian)
as parent or guardian of _____,
(athlete)
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 activities.

USA Hockey provides excess accident coverage with a \$250 deductible
with no other "collectable" insurance and \$100 deductible with other "collectable"
insurance.

If said athlete is covered by any insurance company, please complete the
following:

Name of Carrier _____

Address _____

Policy Number _____

Signed _____

Relationship to athlete _____

Home Address _____

Phone _____ Date _____

MEDICAL HISTORY FORM

Name: _____

Date: _____

Address: _____

Birthdate: _____

Phone(s): Day _____ Evening _____

WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name: _____

Phone(s): _____

Relationship: _____

Physician's Name: _____

Phone(s): _____

Hospital of Choice: _____

PLEASE ANSWER THE FOLLOWING: (If the answer to any of the following questions is or was yes, please describe the problem and its implications for proper first aid treatment on the back.)

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

Circle One

Head injury (concussion, skull fracture)	YES	NO
Fainting spells	YES	NO
Convulsions/epilepsy	YES	NO
Neck or back injury	YES	NO
Asthma	YES	NO
High blood pressure	YES	NO
Kidney problems	YES	NO
Hernia	YES	NO
Diabetes	YES	NO
Heart murmur	YES	NO
Allergies	YES	NO

Specify: _____

Injuries to:

Shoulder	YES	NO
Knee	YES	NO
Ankle	YES	NO
Fingers	YES	NO
Arm	YES	NO
Other _____	YES	NO
Poor vision	YES	NO
Poor hearing	YES	NO

Other: _____

Have you had a recent tetanus booster? If so, when? _____

Are you currently taking any medication? What? Why? _____

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

Signed: _____

(athlete)

(parent or guardian)