



**USA HOCKEY**  
**CONSENT TO TREAT**

This is to certify that on this date, I \_\_\_\_\_, as parent or guardian of \_\_\_\_\_, 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 athlete, for any injury that could arise from participation in USA Hockey sanctioned events.

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

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Signed: \_\_\_\_\_

(parent/guardian)

Relationship to Athlete: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ 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 call Jay Bernard at 1-800-486-6880.

(over, please)

**MEDICAL HISTORY FORM**  
**(COMPLETION OF THIS SIDE OF THE FORM IS OPTIONAL)**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**WHO TO CONTACT IN CASE OF AN EMERGENCY?**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_

**PLEASE COMPLETE 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 a separate piece of paper.

**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 |

Please specify: \_\_\_\_\_

**Injuries to:**

|          |     |    |
|----------|-----|----|
| Shoulder | Yes | No |
| Knee     | Yes | No |
| Ankle    | Yes | No |
| Fingers  | Yes | No |
| Arm      | Yes | No |

Other: \_\_\_\_\_

Impaired vision Yes No

Impaired hearing Yes No

Other: \_\_\_\_\_

**Have you had a recent tetanus booster? \_\_\_\_\_ If so, when? \_\_\_\_\_**

**Are you currently taking any medications? \_\_\_\_\_ What? Why? \_\_\_\_\_**

**Has the doctor placed any restrictions on your activity? \_\_\_\_\_ Explain: \_\_\_\_\_**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Athlete)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent)