



**USA HOCKEY**  
**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 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:

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

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

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

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

(parent/guardian or adult participant)

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 visit [www.usahockey.com](http://www.usahockey.com) or call USA Hockey at 719-576-USAH.

(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: \_\_\_\_\_**  
\_\_\_\_\_