**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.

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| **Emergency Contact**Name: Phone: Address: Physician’s Name: Phone: Hospital of Choice:  |
| **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.❑ Head Injury ❑ Asthma ❑ Allergies *(concussion, skull fracture)* ❑ High blood pressure ❑ Diabetes❑ Fainting spells ❑ Kidney problems ❑ Other ❑ Convulsions/epilepsy ❑ Hernia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❑ Neck or back injury ❑ Heart murmur \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**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 on back. Has a doctor placed any restrictions on your activity? ❑ Yes ❑ No If yes, please explain on back. |