

USA Hockey Consent To Treat/Medical History Form



This is to certify that on this date,	I	, as parent or
guardian of	, (ath	nlete 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, hos	spital, or clinic for the above	e mentioned participant, for any injury
that could arise from participation in	USA Hockey sanctioned e	vents.
If said participant is covered by any	insurance company, please	complete the following:
Insurance Company:		
Policy Number:		
Parent/Guardian/Adult Participant Signature:		Date:
•	ered team participants. For	es, exclusions and certain limitations, further details visit usahockey.com or
EMERGENCY CONTACT		
Name:		Phone:
Address:		
Physician's Name:		Phone:
Hospital of Choice:		
COMPLETION OF MEDIC	CAL HISTORY INFORMATION	ON BELOW IS OPTIONAL
MEDICAL HISTORY If the answer to any of the following of the proper first aid treatment on the limits are the second sec		cribe the problem and its implications
 ☐ Head Injury (concussion, skull fracture) ☐ Fainting spells ☐ Convulsions/epilepsy ☐ Neck or back injury 	□ Asthma□ High blood pressure□ Kidney problems□ Hernia□ Heart murmur	☐ Allergies ☐ Diabetes ☐ Other
Have you had (or do you currently Have you had a recent tetanus boos Are you currently taking any medicat Has a doctor placed any restrictions of	ter? Yes No If yes ions? Yes No If yes	s, when?s, please list all medications on back.