

## USA Hockey Consent To Treat/Medical History Form



This is to certify that on this date,	I	, as parent or
guardian of	, (athlete	e 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.		
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.		
<ul> <li>☐ Head Injury</li></ul>	<ul><li>□ Asthma</li><li>□ High blood pressure</li><li>□ Kidney problems</li><li>□ Hernia</li><li>□ Heart murmur</li></ul>	☐ Allergies ☐ Diabetes ☐ Other
Have you had (or do you currently have) any of the following?  Have you had a recent tetanus booster?		