CONSENT TO TREAT 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 East Aurora Blue Devils 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 AAU 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 $50,000, subject to deductibles, exclusions and certain limitations, is provided to all AAU registered team participants. For further details visit aausport.org

Emergency Contact Name: _____

Phone: _____ Email: _____

Address:_____

Physician's Name: _____

Phone: _____

Hospital of Choice: _____

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 at the bottom of this form in the text field.

Have you had (or do you currently have) any of the following?

❑ 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 a recent tetanus booster? ❑ Yes ❑ No If yes, when? _____

Are you currently taking any medications? ❑ Yes ❑ No If yes, please list all medications on the bottom of this form.

Has a doctor placed any restrictions on your activity? ❑ Yes ❑ No If yes, please explain on the bottom of this form.