USA Hockey National Championships
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: _____

By typing your full name above, you agree this constitutes your legal electronic signature, with the same effect as a handwritten signature.

Excess accident insurance up to $50,000, 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: _____

City: _____ State: _____ Zip Code: _____

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 in the notes box below.

- ☐ Head Injury *(concussion, skull fracture)*
- ☐ Asthma
- ☐ Allergies _____
- ☐ Fainting spells
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Convulsions/epilepsy
- ☐ Kidney problems
- ☐ Other _____
- ☐ Neck or back injury
- ☐ Hernia
- ☐ 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, list in notes box below.

Has a doctor placed any restrictions on your activity? ☐ Yes ☐ No If yes, explain in notes box below.

Notes (medical history details, medications, activity restrictions):