USA HOCKEY

CONSENT TO TREAT

This is to certify that on this date, I __________________________, as parent or guardian of ______________________________, 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 athlete, for any injury that could arise from participation in USA Hockey sanctioned events.

If said athlete is covered by any insurance company, please complete the following:

Name of Insurance Company: ____

Address: ____

Policy Number: ____

Signed: ____
(parent/guardian)

Relationship to Athlete: ____

Home Address: ____

Phone: (__________)___________________________ 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 call Lisa Flores, Talbot Agency, Inc., (505) 828-4064.

To file an excess accident claim, call AIG, (800) 551-0824

(over, please)

MEDICAL HISTORY FORM

(COMPLETION OF THIS SIDE OF THE FORM IS OPTIONAL)

Name: ______________________________ Date: ______________

Address: ______________________________ Birthdate: ______________

____

Daytime Phone: ______________________ Evening Phone: ______________________

WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name: ______________________________ Relationship: ______________

Daytime Phone: ______________________ Evening Phone: ______________________

Physician's Name: ______________________________

Daytime Phone: ______________________ Evening Phone: ______________________

Hospital of Choice: ______________________________

PLEASE COMPLETE THE FOLLOWING:
If the answer to any of the following questions is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have you had (or do you presently have) any of the following?	**Circle One**	
Head injury (concussion, skull fracture)	Yes	No
Fainting spells	Yes	No
Convulsions/epilepsy	Yes	No
Neck or back injury	Yes	No
Asthma	Yes	No
High blood pressure	Yes	No
Kidney problems	Yes	No
Hernia	Yes	No
Diabetes	Yes	No
Heart murmur	Yes	No
Allergies	Yes	No

Please specify: ______________________________

Injuries to:		
Shoulder	Yes	No
Knee	Yes	No
Ankle	Yes	No
Fingers	Yes	No
Arm	Yes	No

Other: ______________________________

Impaired vision	Yes	No
Impaired hearing	Yes	No

Other: ______________________________

Have you had a recent tetanus booster? _____ **If so, when?** ______________________

Are you currently taking any medications? _____ **What? Why?** ______________________

____

Has the doctor placed any restrictions on your activity? _____ **Explain:** ______________________

____

Signed: ______________________________ Date: ______________
(Athlete)

Signed: ______________________________ Date: ______________
(Parent)