

USA Hockey 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:
Parent/Guardian/Adult Participant Signature: Date:		
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:		
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 q for proper first aid treatment on the k	uestions is yes, please describ	
Head Injury	Asthma	Allergies
(concussion, skull fracture)	High blood pressure	Diabetes
 Fainting spells Convulsions/epilepsy 	 Kidney problems Hernia 	❑ Other
Neck or back injury	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, please list all medications on back.		

Has a doctor placed any restrictions on your activity? Yes No If yes, please explain on back.