



# Player Development



## CONSENT TO TREAT FORM (TWO PAGES)

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 participants.

For further details, please visit [www.usahockey.com](http://www.usahockey.com).



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## MEDICAL RELEASE FORM (COMPLETION OF THIS SIDE OF 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?

	<b>Circle One</b>		Injuries to:	<b>Circle One</b>	
Head Injury	YES	NO	Shoulder	YES	NO
Fainting Spells	YES	NO	Knee	YES	NO
Convulsions/Epilepsy	YES	NO	Ankle	YES	NO
Neck or Back Injury	YES	NO	Fingers	YES	NO
Asthma	YES	NO	Arm	YES	NO
High Blood Pressure	YES	NO	Other: _____		
Kidney Problems	YES	NO			
Hernia	YES	NO			
Diabetes	YES	NO	Impaired vision	YES	NO
Heart Murmur	YES	NO	Impaired hearing	YES	NO
Allergies	YES	NO	Other: _____		

Specify: \_\_\_\_\_

Have you had a recent tetanus booster? \_\_\_\_\_ If so, when? \_\_\_\_\_

Are you currently taking any medication? \_\_\_\_\_ What? Why? \_\_\_\_\_

Has the doctor placed any restrictions on your activity? \_\_\_\_\_

Explain: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Athlete)

Signed: \_\_\_\_\_  
(Parent)

Date: \_\_\_\_\_

Date: \_\_\_\_\_