



# Stoughton Youth Hockey Association

P.O. Box 351

Stoughton, WI 53589

www.stoughtonhockey.com

## 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: \_\_\_\_\_

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 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 is yes, please describe the problem and its implications for proper first aid treatment on the back of this form.

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 (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

Has a doctor placed any restrictions on your activity?  Yes\*  No

\*If yes, please explain on back.