BLACK ICE HOCKEY CONSENT TO TREAT FORM

This is to certify that on this date, _____

I _____, as parent or guardian of

_____ give my consent to the Black Ice Hockey Organization 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 Black Ice sanctioned events.

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

Name of Insurance Company: _____

Address: _____

Policy/Group Number: _____

Signed: (Parent/Guardian) _____

Relationship To Athlete: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

MEDICAL HISTORY FORM

Name: _____ Date: _____

Address: _____

Birth Date: _____

WHO TO CONTACT IN THE EVENT OF AN EMERGENCY?

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Physician's Name: _____ Telephone #: _____

Hospital of Choice: (If event is local to home) _____

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 ever had (or do you presently have) any of the following?

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 ____

Specify:

_____

_____

Injuries to:

Shoulder Yes ____ No ____

Knee Yes ____ No ____

Ankle Yes ____ No ____

Fingers Yes ____ No ____

Arm Yes ____ No ____

Other Yes ____ No ____

Specify:

_____

_____

Impaired vision Yes ____ No ____

Impaired hearing Yes ____ No ____

Other: _____

_____

Have you had a recent tetanus booster? Yes ____ No ____ If so, when? _____

Are you currently taking any medications? Yes ____ No ____ What? Why? _____

_____

_____

Has your doctor placed any restrictions on your activity? Yes ____ No ____ Explain: _____

_____

_____

Signed: _____ Date: _____
(Athlete)

Signed: _____ Date: _____
(Parent/Guardian)