

BOULDER HOCKEY CLUB 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 Boulder Hockey Club 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 Boulder Hockey Club events.

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

Insurance Company: _____

Policy Number: _____

Parent/Guardian/Adult Participant Signature: _____ Date: _____

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

| | | |
|--|---------------------|-----------------|
| Head Injury <i>(concussion, skull fracture)</i> | Asthma | Allergies _____ |
| Fainting spells | High blood pressure | Diabetes |
| Convulsions/epilepsy | Kidney problems | Other _____ |
| Neck or back injury | Hernia | _____ |
| | 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.