OFFICIAL
USA HOCKEY CONSENT TO TREAT

MEDICAL & DENTAL CONSENT TO TREAT

Player Name: **DOB:**

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, emergency personnel, or doctor of dentistry, for the above mentioned participant, for any illness or injury, and agree to be financially responsible for the reasonable cost of such assistance and/or treatment.

____________________________________	____________________________________
Parent/Guardian Signature	***Player Signature***
(Required for All Players 18 Years of Age & Under)	***(19 Years of Age or Older Only)***

MEDICAL INSURANCE

(Please Print Clearly – Complete Entire Form)

Policy Holder Name:

Policy Holder Address:

City: **State:** **Zip Code:**

Home Phone: (   ) **Relationship to Athlete:**

Name of Insurance Carrier: **Phone #: (   )**

Carrier Address:

City: **State:** **Zip Code:**

Insurance Policy #: **Insurance Group #:**

DENTAL INSURANCE

(Please Print Clearly – Complete Entire Form)

Policy Holder Name:

Policy Holder Address:

City: **State:** **Zip Code:**

Home Phone: (   ) **Relationship to Athlete:**

Name of Insurance Carrier: **Phone #: (   )**

Carrier Address:

City: **State:** **Zip Code:**

Insurance Policy #: **Insurance Group #:**

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 (712) 576-8724.

(Rev.03/2008)