

# 201%201&IFYHA Registration and Medical History Form

## Player Information:

Last: \_\_\_\_\_ First: \_\_\_\_\_ DOB: \_\_\_\_\_ | Sex: \_\_\_\_\_

## Hockey Division: (check applicable Division)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Mite (2003 and after)  | <input type="checkbox"/> Bantam (1997 and 1998) | <input type="checkbox"/> Girls & PeeWee |
| <input type="checkbox"/> Squirt (2001 and 2002) | <input type="checkbox"/> Midget (1993 – 1996)   | <input type="checkbox"/> Girls & Bantam |
| <input type="checkbox"/> PeeWee (1999 and 2000) | <input type="checkbox"/> Girls Division Only    | <input type="checkbox"/> Girls & Midget |

IFYHA Paypal Receipt Number: \_\_\_\_\_

## Consent to Treat:

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 an insurance company covers said athlete, please complete the following:

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_

## Emergency Contact Information:

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_  
Hospital: \_\_\_\_\_

## Medical History: (check any applicable issues)

- |   |   |                                   |
|---|---|-----------------------------------|
| <input type="checkbox"/> Head Concussion/Skull Fracture | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Arm      |
| <input type="checkbox"/> Convulsions/Epilepsy           | <input type="checkbox"/> Heart Murmur     | <input type="checkbox"/> Ankle    |
| <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Fingers  |
| <input type="checkbox"/> Kidney Problems                | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Impaired Hearing               | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Knee     |
| <input type="checkbox"/> Impaired Vision                | <input type="checkbox"/> Neck/Back Injury |                                   |

Allergies: \_\_\_\_\_

Other (please explain): \_\_\_\_\_

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

Are you currently taking any medications? \_\_\_\_\_ What/Why? \_\_\_\_\_

Has a doctor restricted your activities? \_\_\_\_\_ If yes, explain? \_\_\_\_\_

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

Relationship to Athlete: \_\_\_\_\_