SWYHA CONSENT TO TREAT

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 SWYHA 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 or SWYHA sanctioned events.

If said participant is covered by any insurance, 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: _____

Allergies:

Any known allergies? Yes _____ No _____

If so, what are the allergies? _____

_____