



**USA HOCKEY**  
**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 said athlete is covered by any insurance company, please complete the following:

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Signed: \_\_\_\_\_  
(parent/guardian)

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

Home Address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_

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 call Jay Bernard at 1-800-486-6880.