RoughRider Hockey Club Cedar Rapids

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 RoughRiders Hockey Club Cedar Rapids 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 RoughRiders Hockey Club Cedar Rapids 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	Asthma	Allergies_____________________
(concussion, skull fracture)	High blood pressure	Diabetes
Fainting spells	Kidney problems	Other _______________________
Convulsions/epilepsy	Hernia	____________________________
Neck or back injury	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.