CONSENT TO TREAT

This is to certify that on this date, I ________________________________ as a parent or guardian of ______________________________ (Participant), give my consent to Hampton Inline Hockey 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 Hampton Inline sanctioned events.

Healthcare Provider: ________________________________ **Phone #** ________________

ID/Group #: ________________________________

Physician's Name: ________________________________

Hospital of Choice: ________________________________

Allergies or Special Conditions

(Please include any health issues and/or concussions along with any medication currently taking)

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Date of last Tetanus Booster: __________________________

Any Physicians ordered restrictions: Y or N (If yes, please explain) ________________________________

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Signature: ________________________________ **Date:** ____________

Relationship to Participant: __________________________

Home Address: ________________________________ **State:** ____________ **Zip:** ____________

Phone #: ________________________________

Emergency Contact (different than above) Name: ____________________ Phone # ________________

Relationship to Participant: ____________________