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 USPHL 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 USPHL 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: _____

City: _____ State: _____ Zip Code: _____

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 *(Concussion, skull fracture)*	__ Kidney Problems
__ Fainting spells	__ Hernia
__ Convulsions/epilepsy	__ Diabetes
__ Asthma	__ Allergies: _____
__ High Blood Pressure	__ Other: _____

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.