



Wilkes-Barre Junior Pens Consent to Treat

This is to certify on this date, I/We _____, as
Print Parent/guardian's full name

Parent or guardian of _____
Print player's full name

(athlete/participant, or for myself as an adult participant, give my Consent to the Wilkes-Barre Junior Pens Youth Hockey Organization 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 the Wilkes-Barre Junior Pens's Youth Hockey Program and related events/functions.

If said participant is covered by any Health Insurance Company, please complete the following: (Please print neatly)

Name of Insurance Company: _____

Address: _____

Policy number: _____

Insured Name: _____

Phone number: (usually on back of card) _____

Parent/Guardian Signature: _____

Relationship to participant: _____

Participant's Home address: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Work number: _____

Cell number: _____ Date: _____



All Medical Information contained here-in is Confidential
Medical History Form Wilkes-Barre Junior Pens

Name Player: _____ DOB: _____

Address Mailing: _____

City: _____ State: _____ Zip: _____

Emergency Contact Person's full name: _____

Relationship to Player: _____

Phone #: _____ Cell #: _____

2nd: Emergency Contact Person's full name: _____

Relationship to Player: _____

Phone #: _____ Cell #: _____

Physician/Family Doctor: _____

Physician's Address: _____

City: _____

Physician's phone #: _____

Hospital Choice: _____

Dentist's Name: _____

Phone #: _____

Please complete the following: If the answer to any of the following questions is or was yes, Please describe on this form the problem and its implications for proper first aid treatment.

Have you had (or do you currently have) any of the following:

Head Injury (concussion. skull fracture) _____ Yes No

Fainting Spells _____ Yes No

Convulsions/Epilepsy _____ Yes No

Neck or back injury _____ Yes No

Asthma _____ Yes No

(Provide an inhaler and instructions from doctor to coach)

High Blood Pressure _____ Yes No

Kidney Problems _____ Yes No

Hernia _____ Yes No

Diabetes _____ Yes No

Heart Murmur _____ Yes No

Allergies: _____ Yes No Provide list of Allergies

Do any of the above allergies require the use of one or more EPI-PENS _____?
(Provide epi-pen and instructions from Doctor to coach)

Injuries to:

Shoulder _____ Yes No

Knee _____ Yes No

Ankle _____ Yes No

Wrist _____ Yes No

Fingers _____ Yes No

Arm _____ Yes No

Leg _____ Yes No

Do you wear glasses: _____ Yes No

Do you wear Contacts: _____

Yes

No

Do you wear hearing aids: _____

Yes

No

Are you hearing impaired: _____

Yes

No

Date of your last Tetanus booster: _____

Please list any and all medications you are taking; (including-over the counter meds)

X's/day _____

dosage _____

reason _____

X's/day _____

dosage _____

reason _____

X's/day _____

dosage _____

reason _____

X's/day _____

dosage _____

reason _____

X's/day _____

dosage _____

reason _____

X's/day _____

dosage _____

reason _____

X's/day _____

dosage _____

reason _____

X's/day _____

dosage _____

reason _____

X's/day _____

dosage _____

reason _____

Has the Doctor placed any restrictions on your activity?

Explain: _____

Is there any other medical/physical/psychological/nuerological that the coach should know about that may impact a players performance or needs to be known by medical 1st responders: (if there is any such condition please explain below:
