

ATLANTIC ALL STARS



Consent to Treat

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 USA 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 Atlantic AllStars sanctioned events.

If said participant is covered by any insurance company, please complete the following:

Name of Insurance Company: _____

Address: _____

Policy Number: _____

Signed: _____

(parent/guardian or adult participant)

Relationship to Athlete: _____

Home Address: _____

Phone: (_____) _____ Date: _____