



**USA HOCKEY
PARTICIPANT
CODE OF CONDUCT**

NAME: _____

To be read and signed by you as a member of Team: _____
Participating in USA Hockey for the 2008-2009 season.

1. No swearing or abusive language on the bench, in the rink, or at any team function.
2. No lashing out at any official no matter what the call is. The coaching staff will handle all matters pertaining to officiating.
3. Anyone who receives a penalty will skate directly to the penalty box.
4. Fighting will not be tolerated. Fighting will result in an appearance before a Discipline Committee.
5. There will be no drinking, smoking, chewing of tobacco or use of illegal substance at any team function.
6. I will conduct myself in a befitting manner at all facilities (ice rink, hotel, restaurant, etc) during all team functions.
7. Any player or team official who cannot abide by these rules or violates them will be subject to further disciplinary action.

Signed: _____ Date: _____



USA Hockey

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 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 USA Hockey sanctioned events.

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

Insurance Company: _____

Policy Number: _____

Parent/Guardian/Adult Participant Signature: _____ **Date:** _____

Excess accident insurance up to \$25,000, subject to deductibles, exclusions and certain limitations, is provided to all USA Hockey registered team participants. For further details visit usahockey.com or contact USA Hockey at (719) 576-USAH.

COMPLETION OF MEDICAL HISTORY INFORMATION BELOW IS OPTIONAL

EMERGENCY CONTACT

Name: _____ Phone: _____

Address: _____

Physician's Name: _____ Phone: _____

Hospital of Choice: _____

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.

- | | | |
|---|--|--|
| <input type="checkbox"/> Head Injury
<i>(concussion, skull fracture)</i> | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Convulsions/epilepsy | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Neck or back injury | <input type="checkbox"/> Hernia | _____ |
| | <input type="checkbox"/> 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.

**Criminal Background Check
Release and Disclaimer**

Name: _____
(Print or Type)

Maiden Name: _____

Date of Birth: _____

I, _____
hereby direct and authorize the Bureau of Criminal Identification of the Department
of the Attorney General for the State of Rhode Island to make available to:

**Richard Oliver President
Rhode Island Amateur Hockey Association
73 Verdant Dr.
Cranston, RI 02920**

any criminal record that the Bureau of Criminal Identification
has on file in reference to me.

I hereby waive and release any and all manner of actions,
causes of action, and demands of every kind, nature,
and description, arising from any release of criminal records and requests there from,
whatsoever against the State of Rhode Island, Bureau of Criminal Identification,
the Attorney General, and employees of the Attorney General's Office in both law
and equity which I may now have or in the future may have.

Signature of Applicant

Subscribed and sworn to before me on this ____ day of _____, 2007

Notary Public

My commission expires: _____

NOTE: A copy of a photo ID with D/O/B must accompany this Disclaimer

Photocopy form with Driver's License here,
then sign the **photocopied form**
(make sure photocopy of identification is clear and legible before signing)