

**NEW YORK STATE AMATEUR HOCKEY ASSOCIATION, INC.  
PLAYER/ASSOCIATION COMMITMENT FORM**

INSTRUCTIONS FOR USE:

1. Player/Parent and Association must complete all parts of this form prior to participating with the association, with the exception of tryouts.
2. Both the Player/Parent and the Association shall keep signed copies.
3. After this form is signed by both the Player/Parent and Association, no movement to another association will be allowed until the conclusion of the appropriate State or National Tournaments unless there are extenuating circumstances. A request to be released after this form is signed by all parties and prior to the conclusion of the appropriate State or National Tournaments must be submitted to and approved by the appropriate Section President.

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**PART 1 – To be completed by Player/Parent.**

Player's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I/we agree that the above-named player will be registered and participate on the \_\_\_\_\_ team  
with \_\_\_\_\_ for the season.  
(name of the association)

\_\_\_\_\_  
Signature of Player or Parent (If under 18 years of age)

\_\_\_\_\_  
**Date & TIME**

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**PART 2 – To be completed by the Association's Team Coach.**

I, \_\_\_\_\_ Head Coach, hereby agree that the  
above named player will be registered and participate on my \_\_\_\_\_ team for the season.

Coach's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**PART 3 – To be completed by the Association President.**

On behalf of, and at the direction of the Board of Directors of the \_\_\_\_\_ Association,

I, \_\_\_\_\_ President, do hereby agree that the above named player will be registered,

and participate on our \_\_\_\_\_ team for the \_\_\_\_\_ season.

\_\_\_\_\_  
President's Signature

\_\_\_\_\_  
Date



**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 \_\_\_\_\_ 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 National Championships 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 \$50,000, 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.

### 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.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Head Injury<br><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.