



Collins Elite Hockey

PO Box 5433

Bellingham, WA 98227

[www.collinselitehockey.com](http://www.collinselitehockey.com)

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## Consent To Treat

This is to certify that on this date, I \_\_\_\_\_, as parent or guardian of \_\_\_\_\_ (athlete participant), give my consent to Collins Elite 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 the Collins Elite Hockey Camp.

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

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

Name of Insurance Company: \_\_\_\_\_

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

Policy Number: \_\_\_\_\_

Signed: \_\_\_\_\_

(parent / guardian)

Relationship to Athlete: \_\_\_\_\_

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

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Alt. Phone: (\_\_\_\_\_) \_\_\_\_\_

Date: \_\_\_\_\_