

CONSENT TO TREAT

This is to certify that on this date, _____ I _____
as parent or guardian of _____ give my consent to the Bob
Mancini Summer Hockey School and its medical representative to obtain medical care from any
licensed physician, hospital or clinic for the above mentioned athlete and for any injury that could arise
from participation in the Bob Mancini Summer Hockey School.

Signed: _____ Date: _____

Player's Birthdate: _____

INSURANCE

Name of Insurance Company: _____

Address: _____

Insurance Company Telephone Number: _____

Name of Insured: _____

Policy Number: _____

Group Number: _____

Signature of Insured: _____

Relationship to Athlete: _____

Home Address: _____

EMERGENCY CONTACT NUMBERS

Telephone Numbers

Home: _____

Office: _____

Cellular Phone: _____

Pager: _____

Other: _____