

**WAIKATO HOCKEY ASSOCIATION (INC)
REPRESENTATIVE TEAM
CONFIDENTIAL MEDICAL CONSENT FORM**

Team: _____ **Year:** _____

Player's Name: _____

Date of Birth: _____

Name and Address of Parent or Guardian:

Emergency Contact Phone :

Day: _____

Night: _____

Please State Any Medical Information That Might Be Relevant:

Medication: Please record any medication that is being taken to tournament, and how and when it is to be administered:

Name and Address of Family Doctor:

Ph No. _____

Consent:

In the event of illness or accident, I authorize the obtaining of such medical assistance as may be required.

Community Services Card Number: _____ (Disclosure optional)

Signed _____
(Parent / Guardian / Player)

Date _____