

DO NOT WRITE IN THIS SPACE

FORM _____ BCA+ _____ 4A _____ 4B _____
COMMITTEE _____ APPEAL _____

FORM MUST BE FILLED OUT COMPLETELY
OR APPLICANT SHALL BE DISQUALIFIED
APPLICANT MUST PROVIDE SSN

WHERE WILL YOU COACH OR REFEREE?
Hockey Association _____ MH District _____
(Do not abbreviate name)

MINNESOTA HOCKEY (MH) CONFIDENTIAL SCREENING AND CONSENT FORM

Applicant's Full Name (please print) _____
First Middle Last

Maiden, Alias or Former Name (please print) _____ Telephone number (____) _____

Birth Date (MM/DD/YYYY) ____/____/____ Gender: M ___ F ___ Social Security Number _____
(REQUIRED)

Current Address _____
Street & No. City State Zip

Prior Address if less than 10 Years in MN _____
Street & No. City State Yrs. of Residence

Attach separate sheet if additional space is needed.

Email address for hockey contact _____@_____

What positions do you anticipate holding in the next 12 months? Mark all that apply.

Coach _____ Manager _____ MH Officer/Board/Committee Member _____
Local or District Officer/Board/Committee Member _____ On-Ice Official _____

→ ARE YOU A 1ST YEAR COACH/OFFICIAL? YES ___ NO ___

→ DID YOU COACH WITH THE SAME ASSOCIATION LAST YEAR? YES ___ NO ___

PLEASE NOTE THAT INFORMATION OBTAINED WITH THIS CONSENT FORM RELATING TO BACKGROUND CHECK CRIMES (AS DEFINED ON THE REVERSE SIDE) OR CRIMES INVOLVING THEFT OR DISHONESTY MAY BE DISCLOSED BY MINNESOTA HOCKEY TO ITS AFFILIATE ORGANIZATIONS AND MAY BE USED TO DETERMINE ELIGIBILITY TO PARTICIPATE IN MINNESOTA HOCKEY ACTIVITIES ACCORDING TO MINNESOTA HOCKEY BYLAWS AND POLICY.

1. Do you authorize Minnesota Hockey or related organizations to obtain criminal background check information about you from relevant law enforcement agencies or other screening services? Failure to do so will disqualify you from participation in activities of MH or organizations associated with MH.	1. YES ___ NO ___
2. <u>Have you been convicted</u> of any of the crimes referenced in Minnesota Statutes Chapter 299C, (see list of crimes on reverse side) regardless of where they may have occurred or under which laws they may have been charged or prosecuted? (If you have been convicted, please attach a description of the crime and the particulars of the conviction.) READ AND ANSWER THIS QUESTION CAREFULLY!	2. YES ___ NO ___
3. a) Have you ever been held liable for civil penalties or damages involving sexual or physical abuse of children?	3.a YES ___ NO ___
b) Have you ever been subject to any court order involving sexual abuse or physical abuse of a minor, including, but not limited to, a domestic order for protection?	3.b YES ___ NO ___
c) Have you ever had your parental rights terminated for reasons involving sexual or physical abuse of children?	3.c YES ___ NO ___
If your answer is "YES" to 3 a), b) or c), please attach a description of the facts and the particulars of the case.	
4. Has any of the information entered on this form changed since your last application?	4. YES ___ NO ___
5. Do you authorize Minnesota Hockey to obtain updated criminal background check information about you for so long as you are actively participating in activities of MH or organizations associated with MH? Failure to do so will disqualify you from participation.	5. YES ___ NO ___

BEFORE SIGNING BELOW, BE SURE THAT YOU HAVE CHECKED YES OR NO TO EVERY QUESTION ABOVE AND COMPLETED ALL REQUIRED INFORMATION.

Signature of Applicant _____ Today's Date _____

Signature of Witness _____ Today's 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.

EMERGENCY CONTACT

Name: _____ Phone: _____

Address: _____

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
<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.