NJ Devils Youth Hockey Club
Medical Release & Treatment Form

Player name: _____ Date of Birth: _____ Age: _____

Address. _____ City. _____ State. _____ Zip. _____

Home phone: _____ Email 1: _____ Email 2: _____

Parent/Guardian 1 name: _____ Work phone: _____ Cell phone: _____

Parent/Guardian 2 name: _____ Work phone: _____ Cell phone: _____

Emergency contact 1 name: _____ Relationship: _____ Phone: _____

Emergency Contact 2 name: _____ Relationship: _____ Phone: _____

Insurance carrier, group & policy numbers: _____

Insurance carrier address: _____ Phone: _____

Policy holder's name: _____ Relationship to player: _____

Policy holder's employer: _____ Address: _____

If you answer "yes" to the questions below, please use the back of this form to provide detailed information if necessary

Medical conditions? _____ Medications/dose? _____

Allergies? _____ Previous injuries/date? _____

I certify that my child is in good health, apparently free of communicable disease and fully able to participate in all programs of the New Jersey Devils Youth Hockey Club ("Club"). I understand and agree that the Club recommends each player have a physical examination by his or her physician prior to participation. I give my approval for this player to participate in Club programs. I assume all risks inherent in and incidental to such participation and, further, release, absolve, indemnify, and hold harmless the Club, its officers, directors, organizers, coaches, participants, and rinks from any demand, claim, suit or judgement arising out of player's participation in any program offered by the Club, including but not limited to tryouts, practices, games, transportation, rink facilities, travel to and from rinks, or from or because of an injury, or subsequent care, attention or treatment to the player. I expressly authorize and request the Club and its coaching staff or any member of the organization to act for me and in my behalf according to his or her best judgement in any emergency or injury to my child requesting paraprofessional or professional medical attention or treatment in the event that I am not available or cannot be reached.

Parent/Guardian 1 signature: _____ Date: _____