

2008-09

NJ Devils Youth Hockey Club

Player Emergency Information Profile



Attach wallet size photo here

Player's Name: _____ Today's Date: ____ / ____ / ____

Position: LW RW C DEF Goal Level: _____ Date of Birth: ____ / ____ / ____ Age: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ E-mail 1: _____ 2: _____

Mother's name: _____ Work Phone #: _____ Cell #: _____

Father's name: _____ Work Phone #: _____ Cell #: _____

Other contact: 1 _____ Relationship: _____ Phone #: _____

2 _____ Relationship: _____ Phone #: _____

Physician's Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Medical conditions?: _____ Medications taken?: _____

Allergies to medications / insects etc. if any?: _____

Previous injuries include date: _____

I do hereby request, authorize and consent to such care which may be needed by my child as a result of injury or sickness that the Certified Athletic Trainer, or other qualified medical professional (EMT, DO, MD) on-site provides immediate emergency care, evaluation, treatment, and rehabilitation of an injury. In the case of a more serious injury and I cannot be reached I do hereby, request, authorize and consent for a qualified physician to examine, diagnose, prescribe and perform the treatment necessary for the welfare of the above named player.



Parent Signature: _____ Date: ____ / ____ / 200__