

# Glenview Stars Hockey Association, Inc.

## Emergency Medical Release & Liability Waiver

Participant's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

### EMERGENCY INFORMATION

Father's Name \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Bus Phone (\_\_\_\_\_) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Bus Phone (\_\_\_\_\_) \_\_\_\_\_

*In an emergency when parent/guardian cannot be reached, please contact the following:*

Name \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Bus Phone (\_\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Bus Phone (\_\_\_\_\_) \_\_\_\_\_

Allergies \_\_\_\_\_

Other Medical Conditions \_\_\_\_\_

Physician \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Bus Phone (\_\_\_\_\_) \_\_\_\_\_

Medical/Hospital Insurance Company \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Number \_\_\_\_\_

**THIS AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT MUST BE COMPLETED BEFORE PARTICIPANT (PLAYER) CAN PARTICIPATE IN ACTIVITIES. TREATMENT FOR INJURY WILL BE BASED ON INFORMATION PROVIDED HEREIN.**

I the undersigned (if participant is 18 years of age or older) or parent/guardian of the above listed minor participant acknowledge and fully understand that each participant will be engaging in activities that involve risk of serious injury, including permanent disability or death, and severe social and economic losses which might result not only from their own actions, inactions or negligence, but action, inaction or negligence of others, the rules of play, or the condition of the premises or of any equipment used; and further acknowledge and agree that there may be other unknown risks not reasonably foreseeable at this time, and that I assume all the foregoing risk and accept personal responsibility for the damages following such injury, permanent disability or death, and hereby release, discharge, covenants to indemnify and covenant not to sue Glenview Stars Hockey Association, Inc., its affiliated organizations and sponsors, their coaches, managers, employees and associated personnel, officers, directors, agents, including the owners and leasers of premises used to conduct the event, all of which are hereinafter referred to herein as 'releasees', from any and all liability to each of the undersigned and his/her heirs or next of kin and from and against any claim by or on behalf of the participant as a result of the participant's participation in any the programs and/or being transported to or from the same, which participation, after careful consideration I hereby authorize, and which transportation I hereby authorize. The applicant/participant has received a physical examination by a physician and has been found physically capable of participating in the programs. I hereby give my consent to have an athletic trainer, coach and/or doctor of medicine or dentistry or associated personnel to provide the applicant/participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I, also agree to save and hold harmless and indemnify each and all parties herein referred to above as releasee from all liability, loss, cost, claim or damage whatsoever, including death or damage to property, which may be imposed upon said releasee because of any defect in or lack of such capacity to so act or caused or alleged to be caused in whole or in part by the negligence of the releasee. I have read the above waiver/release and understand that we have given up substantial rights by signing this release and sign below voluntarily. I also understand that this document may not be altered in any manner and that any alteration without the express written consent from the Glenview Stars Hockey Association, Inc will cause the participant to be removed from the program.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(Parent/Guardian's Signature is required if participant is under the age of 18)*

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(Participant's Signature is required if participant is 18 years of age or older)*

**NOTE: ATTACH COPY OF YOUR INSURANCE CARD, FRONT AND BACK, TO EXPEDITE MEDICAL TREATMENT**