

ELEMENTARY/MIDDLE COMMUNITY HOCKEY
REGISTRATION FORM

The main goal of our program is to make hockey a fun, safe, and inclusive sport for all who want to play, regardless of age or ability. However, the Community Hockey League does not allow players to play both minor and community hockey.

This form is to be completed on behalf of a student (male or female) who wishes to participate in Community Hockey and returned to your child's school with payment by Monday, October 1st, 2012. Cash and or cheque will be accepted. You may write the cheque to your son or daughter's school and the school will send all monies collected to the community organization.

The fee for this year will be \$ 50.00 per child or a \$ 90.00 family fee (if you have two or more children enrolled in community hockey)

STUDENT NAME _____ AGE/ GRADE _____

HOME ADDRESS _____ POSTAL CODE _____

HOME PHONE # _____ MEDICARE CARD NO. _____

PARENT/ GUARDIAN _____ WORK PHONE # _____

STUDENT'S PHYSICIAN _____ PHONE # _____

EMERGENCY CONTACT NAME _____ PHONE # _____

ACCIDENT INSURANCE: **YES** **NO** (Please circle one.)

INSURANCE COMPANY: _____

POLICY#: _____

STUDENT ACCIDENT INSURANCE NOTICE-

The Community hockey organization does not provide any accidental death, disability, dismemberment/medical/dental expenses insurance on behalf of the students participating in the activity. For coverage of injuries, you are encouraged to consider your own personal Accident Insurance Plan

Signature of Parent/Guardian _____ Date _____

Thank you- Coaches or persons responsible for the team will be contacting you shortly. When your child(ren) has(have) been placed on a team.

MEDICAL INFORMATION NOTE: An annual medical examination is recommended.

1. Date of last complete medical examination

2. Date of last tetanus immunization:

3. Is your son/daughter/ward allergic to any drugs, foods or medication/other? Yes _____ No _____ If yes, provide details:

4. Does your son/daughter/ward take any prescription drugs? Yes _____ No _____ If yes, provide details:

5. What medication(s) if any should the participant have on hand during the sport activity? _____

Who should administer the medication? _____

6. Does your son/daughter/ward wear a medical alert bracelet _____, neck chain _____ or carry a medical-alert card? Yes _____ No _____

If yes, please specify what is written on it:

7. Does your son/daughter/ward wear eyeglasses? Yes _____ No _____ contact lenses? Yes _____ No _____

8. Please indicate if your son/daughter/ward has been subject to any of the following and provide pertinent details: epilepsy, diabetes, orthopedic problems, deaf, hard of hearing, asthma, allergies

head or back conditions or injuries (in the past two years) _____

arthritis or rheumatism, chronic nosebleeds; dizziness; fainting; headaches; hernia; swollen or hyper mobile joints, trick or lock knee: _____

Any other medical information that will limit participation?

MEDICAL SERVICES AUTHORIZATION

In case of emergency medical or hospital services being required by the above listed participant, and with the understanding that every reasonable effort will be made by the coach or hospital to contact me, my signature on this form authorizes medical personnel and/or hospital to administer medical and/or surgical services including anesthesia and drugs. I understand that any cost will be my responsibility.

SIGNATURE OF PARENT/GUARDIAN _____

DATE: _____

PLEASE NOTE :The information provided on this form will be treated confidentially. In keeping with the principles of the Protection of Personal Information Act, it will be used in relation to the provision of medical assistance to the named student, as appropriate. `

