



PACIFIC COAST AMATEUR HOCKEY ASSOCIATION PLAYER REGISTRATION CERTIFICATE

PLEASE PRINT AND PRESS HARD

FOR ASSOCIATION USE ONLY

MINOR HOCKEY ASSOCIATION			SEASON			INSURANCE NO.		
			20 20					
DIVISION:			TEAM ASSIGNED TO			ASSOCIATION REG. NUMBER		
<input type="checkbox"/> Tyke	<input type="checkbox"/> Novice	<input type="checkbox"/> Atom	<input type="checkbox"/> PeeWee	<input type="checkbox"/> Midget	<input type="checkbox"/> Juvenile	A	B	C

1. IDENTIFICATION:

GIVEN NAME (S) _____ LAST NAME _____

PARENT'S PERMANENT ADDRESS (No., Street, RR#, etc.) _____

CITY/DISTRICT _____ POSTAL CODE _____ TELEPHONE NUMBER () _____ SEX M F

E-MAIL ADDRESS _____ CITIZENSHIP _____

FATHER'S NAME _____ MOTHER'S NAME _____

Phone Number (if different from number above) _____ Phone Number (if different from number above) _____

DATE OF BIRTH	HOCKEY HISTORY (LAST 3 SEASONS PLAYED)		
(Day) (Month) (Year)	Season	Association	Division
			A B C

POSITION _____

2. SIGNATURE AND WAIVER

We hereby acknowledge the authority of Hockey Canada, BC Hockey, Pacific Coast Amateur Hockey Association, and the Minor Hockey Association and agree to carry out and abide by the Constitution, By-Laws, Rules and Regulations of those associations.

EQUIPMENT: We, at the end of the season covered by this registration, agree to return all equipment provided by the Minor Hockey Association, in good condition, and should we fail to do so we agree to reimburse the Association for the replacement cost of such equipment.

RELEASE: In consideration of this application to play under the auspices of the Minor Hockey Association, I do hereby for myself, heirs, executors, administrators and assigns, remise, release, and forever discharge HC, BCH, PCAHA, and the Association, its officers, or anyone acting on their behalf from all manner of litigation, damage claims, or demands in law or equity which I may have or acquire by reason of personal injury, loss or damage to property, which may occur during or by reason of participation in the activities of the Association.

Signature of Player: _____ Signature of Parent: _____

Dated the _____ day of _____, 20 _____.

3. MEDICAL INFORMATION (STRICTLY CONFIDENTIAL)

MEDICAL INSURANCE NUMBER _____ EMERGENCY CONTACT (if parent unavailable) _____ TELEPHONE () _____

LIST ANY DISABILITIES/MEDICAL CONDITIONS:
 Asthma Diabetes Heart Disease Epilepsy
 Other Medical Conditions, Illnesses, or Surgery: _____

REQUIRE THE USE OF:
 Contact Lenses Corrective Lenses

SUFFER FROM:
 Recurring Headaches
 Seizures
 Blackouts
 Chest Pain

LIST ANY MEDICATION(S) TAKEN REGULARLY: _____ LIST ANY ALLERGIES _____

DOCTOR'S NAME: _____ TELEPHONE () _____