

# NON FSJMHA MEMBER U15 TRYOUT REGISTRATION & CREDIT CARD AUTHORIZATION

office@fsjminorhockey.ca

Players trying out for U15 Tier 2 only and not U15 Tracker team must complete this form and CC authorization.

## Player Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City or Town \_\_\_\_\_

Postal Code \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_

Mother Name, Cell and Email: \_\_\_\_\_

Father Name, Cell and Email: \_\_\_\_\_

Home MHA \_\_\_\_\_ MHA registered with the previous season \_\_\_\_\_

**MANDATORY INFORMATION-must be completed** (If you play more than one position please check all that apply to you)

Right Defence    Left Defence    Right Wing    Left Wing    Centre    Shoots Right    Left    Goaltender

Height (ft. – inches) \_\_\_\_\_ Weight (pounds) \_\_\_\_\_

## MEDICAL INFORMATION – must be completed

Care Card Number \_\_\_\_\_ Family Dr \_\_\_\_\_  
(Mandatory)

History of Concussion, if so dates: \_\_\_\_\_

Medic alert Bracelet: Yes    No    Allergies: \_\_\_\_\_

List any medications currently prescribed: \_\_\_\_\_

Any Surgery in past year: Yes    No    Presently Injured: Yes    No

Explain: \_\_\_\_\_

Check any of the following:    Asthmatic    Epileptic    Diabetic    Heart Condition    Glasses    Contacts

Dental Appliance    Hearing Difficulties    Learning Disability

Any further Medial Issues not noted above: \_\_\_\_\_

I understand it is my responsibility to keep HCSP advised of any changes in above information ASAP. In the event of a medical or dental emergency and no one can be contacted, anyone acting on behalf of FSJMA will arrange to take my child to hospital or physician if deemed necessary. I hereby authorize physician or nursing staff to undertake examination, investigation and necessary treatment of child as written above. I also authorize release of information to appropriate people if deemed necessary.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INFORMATION FOR NON FSJMHA MEMBERS ONLY – members must be registered with their home MHA**

- **TRYOUT FEE payment:** Fill out CC authorization form below.

I, \_\_\_\_\_ hereby authorize FSJMHA to bill my

Visa or MasterCard \$150.00 for tryout fees. (Must be paid prior to tryouts)

Credit Card Number: \_\_\_\_\_

Expiry Date: \_\_\_\_\_

Three numbers on back of card: \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_

Contact # of Cardholder: \_\_\_\_\_

Any further questions or information required please email: [office@fsjminorhockey.ca](mailto:office@fsjminorhockey.ca) or check our website [www.fsjminorhockey.ca](http://www.fsjminorhockey.ca)