



# 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                |                                   | A B C  |    | HOCKEY CANADA HOCKEY ID # |  |
| <input type="checkbox"/> Novice | <input type="checkbox"/> PeeWee | <input type="checkbox"/> Midget |                                   |        |    |                           |  |
| <input type="checkbox"/> Tyke   | <input type="checkbox"/> Atom   | <input type="checkbox"/> Bantam | <input type="checkbox"/> Juvenile |        |    |                           |  |

## 1. IDENTIFICATION:

|   |         |  |   |   |          |
|---|---------|--|---|---|----------|
| GIVEN NAME (S)                                      |         |  | LAST NAME                                     |   |          |
| PARENT'S PERMANENT ADDRESS (No., Street, RR#, etc.) |         |  |   |   |          |
| CITY/DISTRICT                                       |         | POSTAL CODE                            |   | TELEPHONE NUMBER                                      |          |
|   |         |  |   | ( )   |          |
| E-MAIL ADDRESS                                      |         |  |   | SEX   |          |
|   |         |  |   | M <input type="checkbox"/> F <input type="checkbox"/> |          |
| 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: <input checked="" type="checkbox"/> | Signature of Parent: <input checked="" type="checkbox"/> |
| Dated the _____ day of _____, 20_____.                   |  |

## 3. MEDICAL INFORMATION (STRICTLY CONFIDENTIAL)

|  |  |  |
|--|--|--|
| MEDICAL INSURANCE NUMBER   | EMERGENCY CONTACT (if parent unavailable)  | TELEPHONE                                    |
|  |  | ( )  |
| LIST ANY DISABILITIES/MEDICAL CONDITIONS:  | REQUIRE THE USE OF:                        | SUFFER FROM:                                 |
| <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Contact Lenses    | <input type="checkbox"/> Recurring Headaches |
| Other Medical Conditions, Illnesses, or Surgery:   | <input type="checkbox"/> Corrective Lenses | <input type="checkbox"/> Seizures            |
|  |  | <input type="checkbox"/> Blackouts           |
|  |  | <input type="checkbox"/> Chest Pain          |
| LIST ANY MEDICATION(S) TAKEN REGULARLY:  | LIST ANY ALLERGIES                         |  |
|  |  |  |
| DOCTOR'S NAME:   | TELEPHONE                                  |  |
|  | ( )  |  |