



PACIFIC COAST AMATEUR HOCKEY ASSOCIATION PLAYER REGISTRATION CERTIFICATE

PLEASE PRINT AND PRESS HARD

FOR ASSOCIATION USE ONLY

MINOR HOCKEY ASSOCIATION				SEASON				
				20	20			
DIVISION:	U9	U13	U18	TEAM ASSIGNED TO	A	B	C	HOCKEY CANADA HOCKEY ID #
	U7	U11	U15					

1. IDENTIFICATION:

GIVEN NAME (S) _____ **LAST NAME** _____

PARENTS PERMINENT ADDRESS (No., Street, RR# etc) _____ **CITY/DISTRICT** _____

POSTAL CODE _____ **MOVE IN YEAR** _____ **TELEPHONE NUMBER** _____ **SEX**
M F O

E-MAIL ADDRESS _____ **CITIZENSHIP** _____ **BIRTH COUNTRY** _____

PARENT NAME _____ **PHONE** _____ **PARENT NAME** _____ **PHONE** _____

ETHNICITY _____ **ABORIGINAL ANCESTRY** _____ **OTHER EMAIL** _____

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

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	REQUIRE THE USE OF: Contact Lenses Corrective Lenses	SUFFER FROM: Recurring Headaches Seizures Blackouts Chest Pain
Other Medical Conditions, Illnesses, or Surgery: _____		

LIST ANY MEDICATION(S) TAKEN REGULARLY: _____	LIST ANY ALLERGIES _____
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DOCTOR'S NAME: _____	TELEPHONE () _ _ _ _ _ _ _ _ _ _ _
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