



Hockey PEI Program of Excellence Registration Form



Please Complete ALL sections and return to the Hockey PEI Office
with applicable \$100.00 registration fee.
Deadline for submission is Friday, March 12, 2010.
Hockey PEI 40 Enman Crescent, Po Box 302, Charlottetown, PE C1A 7K7
Ph: (902) 368-4334 Fax: (902) 368-4337 Email: mike@hockeypei.com

Please Check One:

<p style="text-align: center;">MALE</p> <p><input type="checkbox"/> Under 14 (Born 1997)</p> <p><input type="checkbox"/> Under 15 (Born 1996)</p> <p><input type="checkbox"/> Under 16 (Born 1995)</p>	<p style="text-align: center;">FEMALE</p> <p><input type="checkbox"/> Under 15 (Born 1996, 1997, 1998)</p> <p><input type="checkbox"/> Under 18 (Born 1993, 1994, 1995)</p>
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Name: _____ DOB: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Telephone: _____ Email: _____

Provincial Health Card Number: _____ Fall 2010 School Grade : _____

Height: _____ Weight: _____ Shot (L or R): _____

Preferred Position: 1st Choice _____ 2nd Choice _____

Hockey Team 2009-2010: _____ Coaches Name: _____

Mother/Guardian Name: _____ Contact Number: _____

Father/Guardian Name: _____ Contact Number: _____

Person(s) to contact in case of accident or emergency, if parents are not available:

Name: _____ Telephone: _____

Other

Doctor: _____ Telephone: _____

Dentist: _____ Telephone: _____

OFFICE USE ONLY

Spring	Fee \$:	_____	Method:	_____	Date:	_____
Summer	Fee \$:	_____	Method:	_____	Date:	_____
ACC	Fee \$:	_____	Method:	_____	Date:	_____

Please check the appropriate response below pertaining to your child.

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Previous history of concussions
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Fainting episodes during exercise
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Epileptic
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Wears Glasses
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Are lenses shatterproof
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Wears contact lenses
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Wears dental appliance
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Hearing problem
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Asthma
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Trouble breathing during exercise
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Heart Condition
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Diabetic
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Has had an illness lasting more than a week in the past year
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Medication
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Allergies
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Wears a Medic Alert Bracelet or Necklace
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Does your child have any health problem that would interfere with participation on a hockey team
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Surgery in the last year
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Has been in hospital in the last year
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Has had injuries requiring medical attention in the past year
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Presently injured

Please give details below if you answered "Yes" to any of the above items.

Medications:			
Allergies:			
Medical Conditions:			
Recent Injuries:			
Last Tetanus Shot:		Date of Last Physical:	
Any information not covered above:			

* Any medical condition or injury problem should be checked by your physician before participating in a hockey program.

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible and that in the event no one can be contacted; team management will take my child to hospital/MD if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child.

I also authorized release of information to appropriate people (coach, physician) as deemed necessary.

Date: _____ **Signature of Parent or Guardian:** _____