PACIFIC COAST AMATEUR HOCKEY ASSOCIATION

PLAYER REGISTRATION CERTIFICATE

PLEASE PRINT AND PRESS HARD

FOR ASSOCIATION USE ONLY

MINOR HOCKEY ASSOCIATION

SEASON 20 20

INSURANCE NO.

DIVISION:

☐ U7 ☐ U9 ☐ U11 ☐ U13 ☐ U15 ☐ U18 ☐ U21

TEAM ASSIGNED TO A B C

HOCKEY CANADA HOCKEY ID #

1. IDENTIFICATION:

GIVEN NAME (S)

LAST NAME

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

MOVE IN YEAR

CITY/DISTRICT

POSTAL CODE

TELEPHONE NUMBER ( )

SEX M ☐ F ☐

E-MAIL ADDRESS

CITIZENSHIP

PARENT NAME

Phone Number (if different from number above)

PARENT NAME

Phone Number (if different from number above)

DATE OF BIRTH (Day) (Month) (Year)

POSITION

HOCKEY HISTORY (LAST 3 SEASONS PLAYED)

Season	Association	Division	A	B	C

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: X

Signature of Parent: X

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 ( )

COPY 1 – PCAHA COPY 2 – PCAHA COPY 3 – ASSOCIATION COPY 4 – REGISTRANT