

PACIFIC COAST AMATEUR HOCKEY ASSOCIATION PLAYER REGISTRATION CERTIFICATE

PLEASE PRINT AND PRESS HARD

FOR ASSOCIATION USE ONLY

MINOR HOCKEY ASSOCIATION	SEASON	1	INSURANCE NO.		
		20	20		
DIVISION: Novice PeeWee Midget Tyke Atom Bantam Juvenile	TEAM ASSIC	GNED TO A	A B C HOO	CKEY CANADA HOCKE	EY ID #
	1. IDENTIF	FICATION:			
GIVEN NAME (S)		LAST NAME			
PARENT'S PERMANENT ADDRESS (No., Street, RR#, e	tc.)				
CITY/DISTRICT	POSTA	AL CODE	TELEPHONE NUM	MBER SEX	
E-MAIL ADDRESS			CITIZENSHIP	IVI —	_
FATHER'S NAME		MOTHER'S NAME			
Phone Number (if different from number above)			ımber (if different iber above)		
DATE OF BIRTH (Day) (Month) (Year) Season	HOCKEY I Association	HISTORY (LAST 3 SE	EASONS PLAYED) Divis		A B C
POSITION					
We hereby acknowledge the authority of Hockey Canada, Bourgee to carry out and abide by the Constitution, By-Laws, FEQUIPMENT: We, at the end of the season covered by this condition, and should we fail to do so we agree to reimburse RELEASE: In consideration of this application to play under administrators and assigns, remise, release, and forever dis from all manner of litigation, damage claims, or demands in	C Hockey, Pacificules and Regularegistration, agree the Association or the auspices charge HC, BCI	ations of those associ ee to return all equipm of or the replacement of of the Minor Hockey H, PCAHA, and the A	iations. nent provided by the cost of such equipmer Association, I do association, its office	e Minor Hockey Associa nent. hereby for myself, heir ers, or anyone acting or	ation, in goo s, executor n their beha
property, which may occur during or by reason of participatic Signature of $ \mathbf{X} $				poroonal injury , lood o	l damago
Player:		Parent:			
		Dated the	day of	,	20
3. MEDICAL	INFORMAT	ION (STRICTLY CONF	FIDENTIAL)		
MEDICAL INSURANCE NUMBER EMERGE	NCY CONTACT	Γ (if parent unavailab	ole)	TELEPHONE	
LIST ANY DISABILITIES/MEDICAL CONDITIONS: Asthma Diabetes Heart Disease E Other Medical Conditions, Illnesses, or Surgery:	F pilepsy	REQUIRE THE USE O Contact Lenses Corrective Lense		FFER FROM: Recurring Headache Seizures Blackouts Chest Pain	s
LIST ANY MEDICATION(S) TAKEN REGULARLY:		LIST ANY ALLERG	ilES	_	
DOCTOR'S NAME:		TELEPHONE			