



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	U21					

1. IDENTIFICATION:

GIVEN NAME (S)				LAST NAME					
PARENTS PERMANENT ADDRESS (No., Street, RR# etc)						CITY/DISTRICT			
POSTAL CODE		MOVE IN YEAR		TELEPHONE NUMBER		SEX			
E-MAIL ADDRESS				CITIZENSHIP		BIRTH COUNTRY			
PARENT NAME			PHONE		PARENT NAME			PHONE	
ETHNICITY			ABORIGINAL ANCESTRY			OTHER EMAIL			
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: ☒ **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:				REQUIRE THE USE OF:				SUFFER FROM:			
Asthma Diabetes Heart Disease Epilepsy				Contact Lenses Corrective Lenses				Recurring Headaches Seizures Blackouts Chest Pain			
Other Medical Conditions, Illnesses, or Surgery:											
LIST ANY MEDICATION(S) TAKEN REGULARLY:				LIST ANY ALLERGIES							
DOCTOR'S NAME:				TELEPHONE							
				()							