# PACIFIC COAST AMATEUR HOCKEY ASSOCIATION
# PLAYER REGISTRATION CERTIFICATE

**PLEASE PRINT AND PRESS HARD**

**FOR ASSOCIATION USE ONLY**

**MINOR HOCKEY ASSOCIATION**

**SEASON** 20 20

**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**

**PARENTS PERMINENT 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** (Day) (Month) (Year)

**POSITION**

**HOCKEY HISTORY (LAST 3 SEASONS PLAYED)**

| Season | Association | Division | A | B | C |
|---|---|---|---|---|---|
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## 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** ( )