



## 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 23, 2012.**

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:**

**MALE**

Under 14 (Born 1999,2000)

**FEMALE**

Under 15 (Born 1998, 1999, 2000)

\* Male players born in 1999 or later and female players born in 1997 or later are eligible for the 2015 Canada Winter Games.

\*\* The U15 Male, U16 Male and U17 Female Divisions do not have a Spring Camp. These age groups will have an invite only camp in August. Invites for the August camp will be mailed out in May.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Fall 2012 School Grade : \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shot (L or R): \_\_\_\_\_

Preferred Position: 1<sup>st</sup> Choice \_\_\_\_\_ 2<sup>nd</sup> Choice \_\_\_\_\_

Hockey Team 2011-12: \_\_\_\_\_ 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: \_\_\_\_\_