2013 SUMMER CAMP REGISTRATION FORM

JR. AMERICANS YOUTH HOCKEY PROGRAM (JAYHP)

Player Name:_____ DOB: _____ Age:_____ Gender: M F

Address:_____ City:_____ Zip Code:_____

Age Division (*circle one*): Mite 8 & Under(2006/2005) Squirt 10 & Under(2004/2003) Pee Wee 12 & Under (2002/2001)

Position: (*circle one*): Player 10U | 12U Goalie Last Team Played With:_____

Jersey Size (*circle one*): YS/M YL/XL AS AM AL AXL AXXL GOALIE

T-Shirt Size (*circle one*): YS YM YL AS AM AL AXL AXXL

Parent/Guardian: (A)_____ Relationship:_____ DL#_____

Home Phone #: (A)_____ Work Phone #:_____ Cell Phone #:_____

Email Address: (A)_____

Parent/Guardian: (B)_____ Relationship:_____ DL#_____

Home Phone #: (B)_____ Work Phone #:_____ Cell Phone #:_____

Email Address: (B)_____

EMERGENCY CONTACTS OTHER THAN A PARENT / PERMISSION TO PICK UP PLAYER

Name:_____ DL #: _____ Home #: _____ Work #: _____

Name:_____ DL #: _____ Home #: _____ Work #: _____

WAIVERS

_____Int. My child may_____ /may ***NOT***_____ participate in watching pre-screened hockey blooper and instructional videos. Please check appropriate line.

_____Int. The City of Allen may_____ /may ***NOT***_____ administer medication brought from home in accordance with the instructions given with the medication. Please check appropriate line.

_____Int. Photos may be taken during camp and those photos may be used in marketing or advertising materials.

_____Int. In consideration of your accepting my child's entry to the Jr. Americans Summer Hockey Camp, I hereby, for myself, my child, my heirs, executors and administrators, waive and release any and all rights and claims for damages I or my child may have against the City of Allen, its employees or any volunteers working with the program. The risks involved in respect to such a program are fully understood.

AUTHORIZATION FOR MEDICAL TREATMENT

_____Int. In the event I cannot be reached to make arrangements for medical treatment, I authorize City of Allen employees to administer first aid and/or transportation to the nearest hospital.

Name of Licensed Physician:_____ Phone #:_____

Address:_____ City:_____ Zip Code:_____

1) Please list any health problems or conditions that should be known to the staff (i.e. allergies, medications).

2) Please list any behavioral disorders such as ADHD, Oppositional Defiant Disorder, or anxiety. ***(Optional)***

Parent/Guardian Signature:_____ Date: _____