Rose's
Hockey School of Excellence
(Standard Form)

Please Print

Student's Name: _____ Birth Date: M_____ D_____Y_____

Position Played: _____ Level: ____AAA, ____ A, ____ MD, ____ HL

Weakness: _____ Strengths: _____

Address: _____

City: _____ Postal Code: _____ - _____

Telephone Number: (____) _____ - _____ Alternate Telephone Number: (____) _____ - _____

E-Mail Address: _____

MEDICAL INFORMATION

Health Card Number: _____ Verison Code: _____

List any Medical Conditions which poser skating/hockey skills clinic should be made aware of: _____
_____
_____
_____

Person to Contact in case of an Emergency:

Name: _____ Telephone Number: (____) _____
Family Doctor: _____ Telephone Number: (____) _____

I authorize Hockey Clinic Management to obtain medical attention deemed necessary by the above named person in the event of an emergency. I agree that such acknowledgement is given by me in recognition of the likelihood that in the event of an emergency it may not be practical or possible to obtain my immediate consent to medical treatment. I agree that I will not hold Hockey Clinic Management responsible for medical charges not covered by my insurance, arising from its decision to obtain medical attention for the above mentioned person in the event of any emergency and I agree to such medical services being administrated by Hockey Clinic Management.

***** Note: Hockey Clinic Management WILL NOT be responsible for Lost Equipment or Personal Injury.**

Date: _____ Authorized Signature _____
(of Parent or Guardian)

Parent's Name: _____ Work Place _____
_____ Work Place _____

FOR FURTHER INFORMATION
Please Contact

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