



PROGRAM REGISTRATION

Full Name: _____

Parent's Name: _____

School: _____ Age: ____ Grade: _____

Birth date: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Phone: _____

Emergency Contact: _____

Emergency Contact Phone number: _____

Which way do you shoot? (Right / Left)

Favorite NHL Team? _____ Player: _____

MEDICAL

Special Medical conditions or allergies:

Please advise of any drug/medication administration required:

Medical Service Plan Number: _____

Family Doctor: _____ Tel: _____

FOOD

Do you have any food allergies? YES ____ NO ____

If so please list foods you are allergic to: _____

Are you a vegetarian? YES ____ NO ____

PARENT OR GUARDIAN APPROVAL

Name: _____ Witness: _____

Signed: _____ Date: _____