



Application Form

Player's Name: _____ Gender: _____

Address: _____ City: _____

E-mail: _____

Date of Birth: _____ Health Card # _____

Phone#: _____ Cell Phone#: _____

Name Parent/ Guardian: _____

Hockey experience: _____

Please list any illness that your child has, such as asthma, heart disorders, allergies, etc.:

Please list any prescribed medication that your child is taking and note if and when he/she must take it during the hours of the hockey program.

I understand that this hockey program will be physically demanding and to the best of my knowledge, my above named son/daughter or other is in good health. I also understand and agree except for basic first-aid treatment, SUMMIT Hockey Training Program /SUMMIT Health & Fitness Club will accept no responsibility or liability for accident or illness incurred by a participant/player during the program. I have hereby give my approval for emergency medical treatment, if required. I also agree to have current health insurance coverage for the above named participant. I will in no way hold responsible SUMMIT Hockey Training Program or SUMMIT Health & Fitness Club, or anyone associated with, for medical or dental accidents.

Name of Parent/Guardian (please print): _____

Signature of Parent/Guardian: _____ Date: _____