CARDINAL HOCKEY CLUB
REGISTRATION FORM (Clinic 6 Weeks)

Saturday 9/26, 10/3 (3-5pm) Wednesday 10/7, 10/14, 10/21, 10/28 (6:30-8:30pm)

Player Name:	
Address:	
Date of Birth	
Parental contact:	**Parental contact:**
Parental Email:	**Parental Email:**
Home Phone:	**Home Phone:**
Cell Phone:	**Cell Phone:**

REQUIRED FOR REGISTRATION

	- Completed registration form
	- Fee of $150 Check payable to Cardinals Hockey Club; PO Box 1153, Twp. Of Washington, NJ 07676
	- USA Hockey membership number
	Website: https://www.usahockeyregistration.com/register_form_input.action

CARDINAL HOCKEY CLUB RELEASE

RELEASE FOR PARTICIPATION IN CARDINAL HOCKEY CLUB PROGRAM(S)

WAIVER/AGREEMENT: I agree that I shall provide health insurance, other applicable insurance, to cover any personal injury and property damage sustained by the child while participating in any activities of the Cardinal Hockey Club; and that in consideration of these services provided in connection with the ice skating and hockey program. I hereby and forever discharge the Cardinal Hockey Club, including but not limited to Directors, Officers, Board Members and Coaches from all damages, causes of action, suit, or liabilities for personal injury and or property damage. I/We authorize the Cardinal Hockey Club to seek emergency treatment for our child while a parent is being contacted. I attest that the player is of good health and is able to participate in the physical activity of a rigorous program. Pictures of your hockey player may be used in our flyer or on our web site.

Parent Signature_____ Date: _____

EMERGENCY TREATMENT AUTHORIZATION / CONTACT FORM

As the parent/guardian of the above named child, a minor, I hereby authorize treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger my child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is only granted after a reasonable effort has been made to reach me (at the above listed phone numbers) or my designated alternate as listed below.

Player's Physician:_____ Physician's Phone #: _____

Alternate Emergency Contact:_____ Alt contact Phone #:_____

Relationship:_____

Please note any special allergies, chronic illnesses or other medical conditions medical personnel should be aware of; _____

REQUIRED ICE HOCKEY APPROVED EQUIPMENT TO PARTICIPATE

HECC approved hockey helmet with full face shield, chin strap, mouth guard, padded gloves, skates, hockey girdle with hip protection, protective cup, full knee and shin protection, elbow protection, shoulder pads and stick with butt end.