



2009 REGISTRATION FORM

Hockey Camp

**TO BE COMPLETED BY PARENT OR GUARDIAN.
PRINT IN INK ONLY. FILL IN ALL SECTIONS.**

Your payment, in full, must accompany this registration form

APPLICANT INFORMATION:

Last name *First name* *Middle initial*

USA Hockey# *Birth date (m/d/y)* *Age* *Gender (M/F)*

Home address (#, and Street or PO Box #)

City *State* *ZIP code*

Home phone (include area code) *Parent's E-mail Address*

Mother's/guardian's last name *First name* *Daytime phone* *Home phone*

Father's/guardians last name *First name* *Daytime phone* *Home phone*

Please check all applicable boxes:

Applicant is a member of USA Hockey
 Level of skating _____

Applicant does not belong to USA Hockey

ENROLLMENT INFORMATION: HOCKEY CAMP

CLASS TIMES WILL BE FROM 5:20 pm to 6:30 pm THREE DAYS A WEEK

HOCKEY CAMP ENROLL BY THE DAY: (\$25 Monday, Tuesday though Thursday:

First Week Mon 8/03 Tue 8/04 Thurs 8/06
 Third Week Mon 8/17 Tue 8/18 Thurs 8/20
 Fourth Week Mon 8/24 Tue 8/25 Thurs 8/27

ENROLL BY WEEKLY CAMP (SAVE OFF OF OUR DAILY RATES):

1ST WEEK CAMP -Only \$65 3RD WEEK CAMP -Only \$65 4TH WEEK CAMP -Only \$65
 8/03 - 8/06 (three days) 8/17 - 8/20 (three days) 8/24 - 8/27 (three days)
 HOCKEY CAMP HOCKEY CAMP HOCKEY CAMP

ENROLL BY FULL CAMP (SAVE OFF OF OUR DAILY & WEEKLY RATES):

FULL CAMP -Only \$160
 8/03 - 8/27 (Nine days)
 HOCKEY CAMP

EMERGENCY HEALTH – 2009 Hockey Camp

Last name *First name* *Middle initial*

Birth date (m/d/y) *Age* *Gender (M/F)*

Home address (#. and Street or PO Box #)

City *State* *ZIP code*

Mother's/guardian's last name *First name* *Daytime phone* *Home phone*

Father's/guardians last name *First name* *Daytime phone* *Home phone*

Medical Treatment Authorization

I hereby authorize the clinical staff of The St John's Medical Center to provide care that includes routine diagnostic procedures (i.e., x-rays, blood and urine tests) and medical treatment as necessary to my minor son/daughter, _____.

I understand that the consent and authorization herein granted does not include major surgical procedures and are valid only during the 2009 Jackson Hole Figure Skating Summer Camp. Physical conditions that the clinician should be aware of (allergies, recurring illnesses, disabilities, chronic illnesses, etc.) include:

Date of most recent tetanus immunization: _____
(If more than ten years ago, a booster shot is recommended.)

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency, and if I cannot be reached, I give my consent for physicians and staff at The St. John's Medical Center to perform any necessary emergency treatment. I/We agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider.

Name of emergency contact *Phone*

Name of family physician *Phone*

Parent's or guardian's name (please print)

Signature *Date*

Please indicate (if applicable) HMO PPO

Insurance company Insurance Company address (#. and Street or PO Box #)

City *State* *ZIP code*

Policy subscriber's name *Policy no.* *Group no.*