



2009 REGISTRATION FORM

Figure Skating and Hockey

Learn to Skate Summer Camp

LEARN TO SKATE HOCKEY WILL BE INSTRUCTED BY A HOCKEY COACH

**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:

<i>Last name</i>	<i>First name</i>	<i>Middle initial</i>	
<i>US Figure Skating # or USA Hockey#</i>	<i>Birth date (m/d/y)</i>	<i>Age</i>	<i>Gender (M/F)</i>
<i>Home address (#. and Street or PO Box #)</i>			
<i>City</i>	<i>State</i>	<i>ZIP code</i>	
<i>Home phone (include area code)</i>		<i>Parent's E-mail Address</i>	
<i>Mother's/guardian's last name</i>	<i>First name</i>	<i>Daytime phone</i>	<i>Home phone</i>
<i>Father's/guardians last name</i>	<i>First name</i>	<i>Daytime phone</i>	<i>Home phone</i>

Please check all applicable boxes:

- Applicant is a member of the Jackson Hole Figure Skating Club
- Applicant is a member of US Figure Skating
Highest Basic Skills or Freestyle Test Passed: _____
- Applicant is a member of USA Hockey
Level of skating _____
- Applicant does not belong to US Figure Skating or USA Hockey

ENROLLMENT INFORMATION: LEARN TO SKATE

CLASS TIMES WILL BE FROM 1pm to 2pm EVERY DAY

FIGURE SKATING CAMP ENROLL BY THE DAY: (\$25 Monday though Friday):

First Week	<input type="checkbox"/> Mon 8/03	<input type="checkbox"/> Tue 8/04	<input type="checkbox"/> Wed 8/05	<input type="checkbox"/> Thurs 8/06	<input type="checkbox"/> Fri 8/07
Third Week	<input type="checkbox"/> Mon 8/17	<input type="checkbox"/> Tue 8/18	<input type="checkbox"/> Wed 8/19	<input type="checkbox"/> Thurs 8/20	<input type="checkbox"/> Fri 8/21
Fourth Week	<input type="checkbox"/> Mon 8/24	<input type="checkbox"/> Tue 8/25	<input type="checkbox"/> Wed 8/26	<input type="checkbox"/> Thurs 8/27	<input type="checkbox"/> Fri 8/28

HOCKEY CAMP ENROLL BY THE DAY: (\$25 Monday though Friday):

First Week	<input type="checkbox"/> Mon 8/03	<input type="checkbox"/> Tue 8/04	<input type="checkbox"/> Wed 8/05	<input type="checkbox"/> Thurs 8/06	<input type="checkbox"/> Fri 8/07
Third Week	<input type="checkbox"/> Mon 8/17	<input type="checkbox"/> Tue 8/18	<input type="checkbox"/> Wed 8/19	<input type="checkbox"/> Thurs 8/20	<input type="checkbox"/> Fri 8/21
Fourth Week	<input type="checkbox"/> Mon 8/24	<input type="checkbox"/> Tue 8/25	<input type="checkbox"/> Wed 8/26	<input type="checkbox"/> Thurs 8/27	<input type="checkbox"/> Fri 8/28

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

<input type="checkbox"/> FULL CAMP -Only \$275 8/03 - 8/28 (15 days) LEARN TO FIGURE SKATE	<input type="checkbox"/> FULL CAMP -Only \$275 8/03 - 8/28 (15 days) LEARN TO PLAY HOCKEY
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EMERGENCY HEALTH – 2009 Learn To Skate Summer Camp

<i>Last name</i>	<i>First name</i>	<i>Middle initial</i>	
<i>Birth date (m/d/y)</i>	<i>Age</i>	<i>Gender (M/F)</i>	
<i>Home address (#. and Street or PO Box #)</i>			
<i>City</i>	<i>State</i>	<i>ZIP code</i>	
<i>Mother's/guardian's last name</i>	<i>First name</i>	<i>Daytime phone</i>	<i>Home phone</i>
<i>Father's/guardians last name</i>	<i>First name</i>	<i>Daytime phone</i>	<i>Home phone</i>

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.

<i>Name of emergency contact</i>	<i>Phone</i>
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<i>Name of family physician</i>	<i>Phone</i>
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Parent's or guardian's name (please print)

<i>Signature</i>	<i>Date</i>
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Please indicate (if applicable) HMO PPO

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

<i>City</i>	<i>State</i>	<i>ZIP code</i>
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<i>Policy subscriber's name</i>	<i>Policy no.</i>	<i>Group no.</i>
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