



REGISTRATION FORM

Program _____

Program Date _____

Name: _____

Address: _____

City: _____

Postal Code: _____

Home phone # _____

Email (if applicable) _____

Fax (if applicable) _____

Health card number: _____

D.O.B. _____

Family Doctor: _____

Doctor's phone number: _____

Hockey Team _____

City _____

Position _____

Rep/ House League _____

Other sports _____

Consent and Waiver

I/we _____

(Parent(s)/Guardian(s))

hereby give permission to _____

to participate in _____, and do hereby agree to release all program staff and volunteers from any personal injury or harm and/or damage to or loss of personal items incurred during the program. It is understood that the program is designed to offer a safe and supervised environment.

Name(s) please print: _____

Signature(S) : _____

Date : _____

MAIL TO:
Kawartha Hockey Centre
c/o 560 Romaine Street
Peterborough, Ontario
K9J 2E3