



PLAYER APPLICATION FORM 2009-2010

Player's Name: _____

Address: _____ *Postal Code:* _____

Home Phone: (705) _____ *email:* _____

Date of Birth (YY/MM/DD): _____ *Age:* _____ *Gender (circle one):* Male / Female

Level (circle one) *Prenovice (Timbits)* *Novice* *Atom* *Peewee* *Bantam* *Midget*

Last Year's Team: _____ *Position (circle one):* Forward Defense Goalie

Has your address changed since the last hockey season? YES / NO (if yes please fill out NOHA Player transfer form)

Guardians' Names: (1) _____ (2) _____

Home Phone: _____ _____

Work Phone: _____ _____

Cell Phone: _____ _____

EMERGENCY CONTACT: (if guardian not available)

Name: _____ *Phone:* _____

Family Doctor: _____ *Phone:* _____

Family Dentist: _____ *Phone:* _____

PLEASE ANSWER YES/NO TO THE FOLLOWING QUESTIONS REGARDING THE ABOVE PLAYER:

- | | | | | | |
|-----|----|--------------------------------------|-----|----|---|
| YES | NO | <i>Wears glasses?</i> | YES | NO | <i>Hearing problems?</i> |
| YES | NO | <i>Are lenses shatterproof?</i> | YES | NO | <i>Trouble breathing during exercise?</i> |
| YES | NO | <i>Wears contacts?</i> | YES | NO | <i>Epileptic?</i> |
| YES | NO | <i>Asthma (usage of a puffer)?</i> | YES | NO | <i>Allergies?</i> |
| YES | NO | <i>Heart condition?</i> | YES | NO | <i>Surgery in the last year?</i> |
| YES | NO | <i>Diabetic?</i> | YES | NO | <i>Has had medical injuries in the last year?</i> |
| YES | NO | <i>Wears a Medic Alert bracelet?</i> | YES | NO | <i>Presently Injured?</i> |
| | | | YES | NO | <i>May receive blood transfusion if needed?</i> |

Please give details if you answered YES to any of the above question(s):

Medications: _____ *Allergies:* _____

Medical Conditions: _____

Recent Injuries: _____

Additional Info: _____

Any medical condition or injury should be checked by your Physician before returning. I understand that it is **MY** responsibility to keep KLMHA and team management advised of any change in the above information ASAP. I also give permission, that in the event that no one can be contacted, the team management/trainer will take my child to the Hospital/MD if deemed necessary. I hereby authorize the Physician and Nursing staff to undertake examination, investigation and necessary treatment of my child.

Signature of Guardian: _____ *Date:* _____