## 2024 – 2025 MEI Hockey Academy
## Application Form

Last Name: _____ First Name: _____

DOB: _____ Gender: ____ Parents Name: _____

Address: _____

Phone Number: _____ E-mail Address: _____

Current School: _____ Current Grade: _____

Current Level: (exp. U6, U8, U9, U11, A1, A2, A3, Rec, Christian League): _____ Position: _____ Years Played: _____

Jersey Size: YS / YM / YL / YXL / AS / AM / AL / AXL / Goalie Cut (circle one)

Sock Size: XS / S / M / L / XL (circle one)

| **Elementary School**<br>○ Grade 2-5<br>$1,250 ($250 processing fee + $1000 player fee) | **Middle School**<br>○ Grade 6-8<br>$1,250 ($250 processing fee + $1000 player fee) |
|---|---|
| □ 7 month program<br>(Sept-March)<br>Wednesday 7:30-8:30am Ice Time @ Summit East<br>Wednesday 12:20-12:50pm Gym Hockey @ MEI | □ 7 month program<br>(Sept-March)<br>Wednesday 7:15-8:15am Ice Time @ Summit West<br>Wednesday 11:30-12:05pm Gym Hockey @ MEI |
| □ Goalie Fee<br>$500 1 time payment | □ Goalie Fee<br>$500 1 time payment |

**Parent/Student Authorization:**
I/we certify the information given in this application is accurate.

Parent Signature: _____ Date: _____

**Please drop off the following at the MEI Elementary School Office:**

- ❑ Completed Application Form & Medical Form

**Please Note:**

- **Non-refundable** $250 Processing Fee (via School Cash Online)
- Player fee will be processed via School Cash Online

**For Office Use Only**
Processing Fee ____
Player Fee ____
Accepted ____

## MEDICAL INFORMATION SHEET

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____

Telephone: ( ____ ) _____ Cell: ( ____ ) _____

Provincial Health Number (optional): _____

**Parent/Guardian #1:** Name _____

Business Phone Number:( ____ ) _____

**Parent/Guardian #2:** Name _____

Business Phone Number:( ____ ) _____

**Alternate emergency contact (if parents are not available)**

Name: _____

Relationship to Player: _____

Telephone: ( ____ ) _____ Cell: ( ____ ) _____

**Doctor's Name:** _____

Telephone: ( _____ ) _____

**Dentist's Name:** _____

Telephone: ( _____ ) _____

Date of last complete physical examination: _____

*Before a player participates in a hockey program it is recommended that they have a medical and that they also have any medical condition or injury problem checked by their family physician*

**Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.**

Yes ❑ No ❑ Medication

Yes ❑ No ❑ Allergies

Yes ❑ No ❑ Previous history of concussions

Yes ❑ No ❑ Fainting or seizure during or after physical activity

Yes ❑ No ❑ Near fainting or Brownouts

Yes ❑ No ❑ Seizures and/or epilepsy

Yes ❑ No ❑ Wears glasses

Yes ❑ No ❑ Are lenses shatterproof

Yes ❑ No ❑ Wears contact lenses

Yes ❑ No ❑ Wears dental appliance

Yes ❑ No ❑ Hearing problem

Yes ❑ No ❑ Asthma

Yes ❑ No ❑ Trouble breathing during exercise

Yes ❑ No ❑ Heart Condition

Yes ❑ No ❑ Palpitations or Racing Heart

Yes ❑ No ❑ Family history of heart disease

Yes ❑ No ❑ Family history of unexpected death during physical activity

Yes ❑ No ❑ Family history of unexplained death of a young person

Yes ❑ No ❑ Diabetes – Type 1____ Type 2_____

Yes ❑ No ❑ Wears medical information bracelet/necklace
For what purpose? _____

Yes ❑ No ❑ Health problem that would interfere with participation on a hockey team

Yes ❑ No ❑ Has had an illness that lasted more than a week and required medical attention in the past year

Yes ❑ No ❑ Has had injuries requiring medical attention in the past year

Yes ❑ No ❑ Been admitted to hospital in the last year

Yes ❑ No ❑ Surgery in the last year

Yes ❑ No ❑ Presently injured
Injured body part: _____

Yes ❑ No ❑ Vaccinations up to date
Date of last Tetanus Shot:_____

Yes ❑ No ❑ Hepatitis B vaccination

**Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)**

_____

_____

_____

Medications:_____

Allergies: _____

Medical conditions: _____

Recent injuries: _____

Any information not covered above: _____

_____

I understand that it is my responsibility to keep the team Safety Person advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child. I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date: _____ Signature of Player: _____

Date: _____ Signature of Parent or Guardian: _____

*Disclaimer: Personal information used, disclosed, secured or retained by Hockey Canada will be held solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act as well as Hockey Canada's own Privacy Policy.*