Foothills Skating Club #1000702

Box 1266, Black Diamond, AB, T0L 0H0
Contact us: registration@foothillsskatingclub.ca

CanPowerSkate Clinic 2018-2019

Skater's Last Name: _____ Skater's First Name: _____

Skate Canada #: _____ Gender: Male ☐ Female ☐ DOB (MM/DD/YYYY): _____

Street/Legal Land Address: _____ Mailing Address: _____

Town/ City: _____ Province: _____ Postal Code: _____

Phone (Home): _____ Phone (Cell): _____ Email Address: _____

Parent/Guardian Names: _____

CanPowerSkate Clinic

Please indicate the current hockey level of the skater:

Initiation/Tigermite | Peewee
Novice | Bantam
Atom | Midget

		AMOUNT
CanPowerSkate - Fall 2018 Session October 2, 2018 to December 18, 2018	Tuesdays 4-5pm 11 x 1 hour sessions **$ 275.00**	
CanPowerSkate – Winter 2019 Session January 8, 2019 to March 12, 2019	Tuesdays 4-5pm 9 x 1 hour sessions **$ 225.00**	
CanPowerSkate – Full Year 2018-2019 October 2, 2018 to March 12, 2019	Tuesdays 4-5pm 20 x 1 hour sessions **$ 450.00**	
	Fee before Registration Fees:	
	Registration Fee (includes Skate Canada & Admin Fees):	**$ 50.00**
	TOTAL Fees Due	**$**

Online registration and payment is available through our website. All fees are to be PAID IN FULL prior to the first scheduled day of the program. See our Fee & Payment Policy for more details.

A $25 charge is payable for any payments made to the club returned from your bank due to non-sufficient funds or stop payment.

For Office Use Only:

Volunteer Cheque Rec'd: _____ Cheque #: _____

Payment Received: Cash $ _____ PayPal $ _____ Cheque $_____ Cheque # _____

Deposit # _____ Date:_____

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Date:

Allergy/Medical Alert Form

Skater Information:

Please note: The information on this form is collected for Emergency use only, and is kept confidential.

Name of Skater: _____ DOB: _____

Address: _____ Medic Alert ID# _____

Alberta Health Care # (Optional): _____

Name of Parent/Guardian: _____

Home Phone #: _____ Cell Phone #: _____

Emergency Contact Person(s):

Name:_____

Home Phone # _____ Cell Phone #: _____

Name:_____

Home Phone # _____ Cell Phone #: _____

Health & Physician Information:

Nature of Allergy/Medical Condition:

_____

_____

Symptoms of Reaction:

_____

_____

Recommended Response to Reaction:

_____

_____

Additional Instructions or Information:

_____

_____

NAME OF PHYSICIAN:_____

TELEPHONE #:_____