Foothills Skating Club #1000702

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

Preliminary Prep Program 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:

Preliminary Prep Program - 1 or 2 hours per week including coaching for all hours on ice					**TOTAL**
Level 5 (Entry – first step above CanSkate)	Oct 5/18 – Mar 15/19 21 weeks	21 hours	Fridays 4:00-5:00pm	$ 275.00	
Level 6 (Advanced)	Oct 1/18 – Mar 22/19 22 weeks	44 hours	Mondays & Fridays 4:00-5:00pm	$ 550.00	
				Fee before Registration & Picture Fees:	
				Picture Fee (includes one 5x7 professional photographer picture of above skater):	**$ 15.00**
				Registration Fee (includes Skate Canada & Admin Fees):	**$ 50.00**
				TOTAL Fees Due	**$**
Preliminary Prep Volunteer Commitment – 15 Points per season/family - Cheque dated July 1, 2019 - **$250.00** **Volunteer bond needs to be handed in on the first day of skating**					

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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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 #:_____