

Georgia Student Hockey League

(Registration 2008-2009)

(All fields **MUST** be completed and legible)



Student's Name: _____ Birth Date: ____/____/____

Parent/Legal Guardian Name(s): _____

Address: _____

City: _____ State: GA Zip: _____

County: _____ US Citizen: Yes - No (If no, see below)

Gender: M F Positions: Forward - Defense - Goalie Shoots: Left - Right

Telephone Number: (Day) _____ (Evening) _____

E-mail Address: _____

High School (currently attending): _____ Grade: _____

Public High School District in which you reside: _____

Previous GSHL membership (circle one) Yes No

If "Yes", name of team for which student played for: _____

Years played Ice Hockey: _____

Additional Information (other league membership, etc.) _____

Requirements:

Current Georgia High School Student with passing grades, not under suspension and no involvement with drugs or alcohol.

Each player must submit a copy of their student identification card with the team roster.

Registration and Insurance:

We will be playing under USA Hockey, and Southern Amateur Hockey Association.

Non-US citizens only:

Per International Ice Hockey Federation (IIHF) regulations, a transfer is required for all non-US citizens, even if they did not play hockey in the country of their citizenship. Per IIHF transfer regulations Canadian and European players, men or women, under 18 years of age may be transferred by means of a letter of approval. Written transfers are processed for one season only and there is no fee for written transfers. Please see your team representative for information for the transfer.

Player sign: _____ Date: _____

Parent sign: _____ Date: _____



**USA HOCKEY
PARTICIPANT
CODE OF CONDUCT**

NAME: _____

To be read and signed by you as a member of Team: _____
Participating in USA Hockey for the 2008-2009 season.

1. No swearing or abusive language on the bench, in the rink, or at any team function.
2. No lashing out at any official no matter what the call is. The coaching staff will handle all matters pertaining to officiating.
3. Anyone who receives a penalty will skate directly to the penalty box.
4. Fighting will not be tolerated. Fighting will result in an appearance before a Discipline Committee.
5. There will be no drinking, smoking, chewing of tobacco or use of illegal substance at any team function.
6. I will conduct myself in a befitting manner at all facilities (ice rink, hotel, restaurant, etc) during all team functions.
7. Any player or team official who cannot abide by these rules or violates them will be subject to further disciplinary action.

Signed: _____ Date: _____



USA Hockey

Consent To Treat/Medical History Form



This is to certify that on this date, I _____, as parent or guardian of _____, (athlete participant), or for myself as an adult participant, give my consent to USA Hockey and its medical representative to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury that could arise from participation in USA Hockey sanctioned events.

If said participant is covered by any insurance company, please complete the following:

Insurance Company: _____

Policy Number: _____

Parent/Guardian/Adult Participant Signature: _____ **Date:** _____

Excess accident insurance up to \$25,000, subject to deductibles, exclusions and certain limitations, is provided to all USA Hockey registered team participants. For further details visit usahockey.com or contact USA Hockey at (719) 576-USAH.

COMPLETION OF MEDICAL HISTORY INFORMATION BELOW IS OPTIONAL

EMERGENCY CONTACT

Name: _____ Phone: _____

Address: _____

Physician's Name: _____ Phone: _____

Hospital of Choice: _____

MEDICAL HISTORY

If the answer to any of the following questions is yes, please describe the problem and its implications for proper first aid treatment on the back of this form.

- | | | |
|---|--|--|
| <input type="checkbox"/> Head Injury
<i>(concussion, skull fracture)</i> | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Convulsions/epilepsy | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Neck or back injury | <input type="checkbox"/> Hernia | _____ |
| | <input type="checkbox"/> Heart murmur | _____ |

Have you had (or do you currently have) any of the following?

Have you had a recent tetanus booster? Yes No If yes, when? _____

Are you currently taking any medications? Yes No If yes, please list all medications on back.

Has a doctor placed any restrictions on your activity? Yes No If yes, please explain on back.