

Hockey Program Team Registration Form



All information is confidential for ACMC use only—Please complete prior to initial evaluation.

**Cost: \$495.00 per person normally
\$250.00 per person in groups of 4**

Team Registration Policy

- Program available to those 12 years of age or older.
- Team pricing: \$250.00 for group of 4
- Price includes 18 visits of 60-90 minutes each (1 initial evaluation, 16 hockey specific workouts including hockey treadmill and sport-specific strengthening, 1 re-evaluation)
- All unused appointments expire after 3 months from date of initial evaluation.
- Team Pricing: All registrations must be received using team registration sheet; All individuals of “team” must be in attendance together during each evaluation and workout; those individuals absent do not receive a makeup appointment.
- All visits by appointment only. Use team captain’s name for scheduling purposes.

Team Captain Name (this will be your identifier for scheduling purposes): _____

Please list each team member participating in the ACCEL Hockey Program
(minimum of 4 people required for team discount).

1. _____ 2. _____
3. _____ 4. _____

NOTE: Each team member is required to complete the Participant Health Questionnaire/Parent Permission form on the next two pages.

NOTE: The completed *Team Registration Form* and all completed/signed *Participation Health Questionnaire/Parental Permission Forms* must be presented when making payment to cashier to receive team discount.

Hockey Program Participant Health Questionnaire & Parental Permission Form



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Name (last, first) _____

Address: _____ City, State, ZIP _____

Phone (____) _____ School _____ Birthdate ____/____/____

Family Physician _____ Address _____

City, State, ZIP _____ Phone _____

Date of last Physical or Pre-Participation Examination _____

Please list two individuals we may contact in case of emergency.

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

Have you experienced any of the following?

(Please explain all YES answers in the space provided on the back)

Y	N	Coughing, shortness of breath or chest pain?
Y	N	Numbness in any part of the body?
Y	N	Headaches, dizziness, weakness, fainting, or problems with coordination or balance?
Y	N	Difficulties with blurry vision?
Y	N	Problems with skin such as sores, rashes, itching or burning sensation, etc.?
Y	N	Stiffness, swelling or pain related to your muscles, bones or joints?
Y	N	Dehydration (excessive loss of water)?
Y	N	Heat stroke or other heat-related disorders?
Y	N	Head injury causing loss of memory, unconsciousness or vomiting?
Y	N	Epilepsy (Seizures)?
Y	N	Tuberculosis, asthma or any lung disease or respiratory disorder?
Y	N	Mononucleosis, diabetes, goiter or any other disease of the glands?
Y	N	Significant weight change in the past year?

For Office Use Only
PN: _____
RN: _____

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Have you experienced any of the following? (cont'd)

(Please explain all YES answers in the space provided below):

Y	N	Hospitalization in the past 12 months for any reason?
Y	N	Current use of any medications?
Y	N	Use of nutritional supplements to aid training or performance?

Females only:

AT WHAT AGE DID YOU FIRST MENSTRUATE? _____

HOW REGULAR ARE YOUR PERIODS NOW? _____

ANY OTHER MENSTRUAL ABNORMALITIES OR CONCERNS AT THIS TIME ? _____

Use space below to explain "Yes" answers

My signature below certifies that the information provided above is true.

Participant's signature _____

_____ Date

Parent's signature (Required if participant is a student) _____

_____ Date