



Enrolment Form

Xmas Day Camp 28th December 2019

Oxford Ice Rink, Oxpens Road, Oxford, OX1 1RX

Please PRINT clearly

Full Name: **Male/Female** **DOB:** **Age:**

Address: **Postcode:**

Phone Number: **Email Address:**

Please Circle:

Player Experience: Club / GB and **Position you play:** Forward / Defence / Goaltender

Emergency contact Name: **Phone No:**

Relationship to you:

For promotional purposes photographs are taken during AHDUK Camps.

Please tick; I DO I do NOT consent to photographs of me being used for promotional purposes

Please Sign: **Date:**

Cost per Camp is £50 Players, £30 Goalies each (Please Note; payment is non-Refundable on cancellations)

We offer 5% sibling discount = £47.50 per child

Total Paid £

Please provide sibling name/s attending the Camp/s:

1) 2)

Payment Method:

- BACs - For Secure Online Bank Transfer; Sort Code – 208458 – Account Number – 53812901
- Scan and email your completed Enrolment form to: peter.winn@ahduk.com *Alternatively;* Post your completed Enrolment form to: Mr P Winn, 56 Casterbridge Rd, Swindon, Wilts, SN25 1RD

IMPORTANT - Waiver – Please read

Advanced Hockey Development uk and its instructors shall not be held liable for any damages or injury to me however caused. I hereby discharge Advanced Hockey Development uk and its Instructors from all actions and claims I have for any such injury or damage. This waiver covers all on and off ice activities. Participants will be liable for the repair of any damage to the facility.

Medical History

Name: _____

DOB: _____

Have you ever suffered from the following?

Asthma YES / NO Diabetes YES / NO Epilepsy YES / NO Heart Complaints YES / NO

Are you required to have medication with you when taking part in sport? YES / NO

If Yes, please name your medication and how often you need to take;

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Do you have any allergies? YES / NO

If yes, please specify;

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Do you have any diet restrictions? YES / NO

If yes, please specify

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Have you had any injuries to the head? YES / NO

If yes, please provide date/year?

Where you unconscious? YES / NO

If yes, for how long? Hours..... Days.....

Do you have any other illness/ injuries that may affect your participation?

YES / NO

If yes, please specify

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Signed:

Print Name: Date:

Contact Number: Relationship:

The above medical information will be kept Private and Confidential and will be used for medical emergencies only.

IMPORTANT – It is your responsibility to complete a new Medical form if there are any changes whatsoever to your child's health.