

Stafford Township Girls Field Hockey League 2016 FALL REGISTRATION

Fees \$75 per child, \$100 per Family – The season runs from the week of August 22- and run through the end of October

Please include a copy of child's birth certificate to registration.

CAN BE MAILED TO 260 EAST BAY AVENUE MANAHAWKIN, NJ 08050 OR YOU CAN DROP OFF REGISTRATION BETWEEN 10 AM -4:00 PM MONDAY –FRIDAY PINE STREET RECREATION BUILDING 25 PINE STREET IN PERSON REGISTRATION IS THURSDAY JULY 28 FROM 4-6 AT THE OCEAN ACRES COMMUNITY CENTER
2nd- 6th grade

Players are grouped by age and /or ability to optimize the level of coaching. Our coaches will be teaching and reinforcing the fundamentals of the game with a positive creative approach to learning. Players will progress to game situations and will learn positions/ game strategy as well as skills.

PLAYER INFORMATION

NAME: _____
ADDRESS: _____
DATE OF BIRTH: _____ GRADE: _____ SCHOOL: _____
KNOWN MEDICAL PROBLEMS OR ALLERGIES: _____

PARENT INFORMATION

NAME (S): _____
ADDRESS: _____
HOME PHONE: _____ CELL PHONE: _____
E-MAIL: _____

EMERGENCY CONTACT INFORMATION

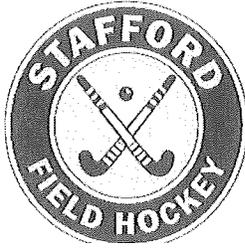
NAME: _____
RELATIONSHIP: _____
HOME PHONE: _____ CELL PHONE: _____

LIABILITY WAIVER

I certify that my daughter is in good health to participate in the program's activities. Further, I authorize Stafford Recreation Girls Field Hockey League to act for me according to their best judgment in an emergency requiring medical attention. I am aware that Stafford Recreation Girls Field Hockey League or its coaches are not responsible for injuries or accidents as a result of participation.

Parent Signature _____

Shirt Size (youth to adult) _____



Stafford Field Hockey Medical Form

Medical History Questionnaire

Today's Date: _____

*Date of last Physical: _____

Date of last Tetanus: _____

**All athletes participating in USA Field Hockey programs must have received a physical examination from a physician within the past 12 months and the physical examination date must be within the 12 month period of the USA Field Hockey Program dates.*

Athlete's Name: _____ Sex: M F Birth Date: _____ Age: _____

Address: _____

City: _____ State _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Information

Parent 1: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Parent 2: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Medical Insurance Information

Medical Insurance Company Name _____

Policy / Group Number _____

Name of Policy holder _____ Relationship: _____

Medical History

Please answer the following questions about the student athlete. Explain all 'yes' responses at the bottom of the page. Please respond to all questions.

Have you had or do you currently have:

- | | | |
|-----|----|--|
| YES | NO | A sports physical within the past 365 days? |
| YES | NO | An injury or illness since your last exam? |
| YES | NO | A chronic or ongoing illness (such as diabetes or asthma): |
| YES | NO | Do you use an inhaler or other prescription medication to control asthma? |
| YES | NO | Any prescribed or over the counter medications that you take on a regular basis? |
| YES | NO | Surgery, hospitalization or any emergency room visit(s)? |
| YES | NO | Any allergies to medications? |
| YES | NO | Any allergies to bee stings, pollen, latex or foods? |
| | | Type of reaction: circle all that apply..... Rash? Hives? Other skin conditions? |
| | | Take any medication / EpiPen taken for allergy symptoms (List below) |
| YES | NO | Any anemia or blood disorders? |

Have you had or do you currently have any of the following head-related conditions since your last physical?

- | | | |
|-----|----|--|
| YES | NO | Concussion requiring a physician's evaluation? |
| YES | NO | Memory loss or been knocked out? |
| YES | NO | A seizure? |
| YES | NO | Frequent or severe headaches? |

Have you had or do you currently have any of the following heart-related conditions since your last physical?

- | | | |
|-----|----|--|
| YES | NO | Chest pain? |
| YES | NO | Heart murmur? |
| YES | NO | High blood pressure or elevated cholesterol level? |
| YES | NO | Restrictions from sports for heart problems? |

Have you had or do you currently have any of the following eye, ear, nose, mouth or throat conditions since your last physical?

- | | | |
|-----|----|---|
| YES | NO | Vision problems? (Circle all that apply) Wear contacts, eyeglasses or protective eye wear |
| YES | NO | Hearing loss problem? |
| YES | NO | Nasal fractures or frequent nose bleeds? |
| YES | NO | Wear braces, retainer or protective mouth gear? |
| YES | NO | Frequent strep or any other conditions of the throat? |

Have you had or do you currently have any of the following neuromuscular/orthopedic conditions since your last physical?

- YES NO A burner, stinging or pinched nerve
- YES NO A sprain or strain
- YES NO Swelling or pain in muscles, tendons, bones or joints?
- YES NO A dislocated joint(s)?
- YES NO Upper or lower back pain?
- YES NO Fracture(s) or stress fracture(s)?
- YES NO Do you wear any protective braces or equipment for any prior injury?

Have you had or do you currently have any of the following general or exercise related conditions since your last physical?

- YES NO Difficulty breathing: (a) after running one mile; (b) coughing, wheezing or shortness of breath in weather changes, (c) Exercised-induced asthma.
- YES NO Viral infections (e.g. mono, hepatitis)?
- YES NO Heat-related problems (dehydration, dizziness, fatigue, headache)?

Explain all YES answers here (include relevant dates):

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature and that my daughter / son (circle) has had a physical examination by a physician within the past year, inclusive of the date of the Stafford Field Hockey program the athlete will be participating.

Parent / Guardian Signature: _____ Date: _____

Print Name of athlete: _____

Print Name of parent / Guardian: _____

Program: _____

Stafford Field Hockey

RELEASE AND MEDICAL TREATMENT AUTHORIZATION

In consideration of and through my involvement in this Stafford Field Hockey program I (or on behalf of my minor child) acknowledge and agree I RISK BODILY INJURY, INCLUDING PARALYSIS, DISMEMBERMENT, and DEATH, as well as LOSS OF or DAMAGE TO PROPERTY; I KNOWINGLY AND FREELY ASSUME ALL SUCH RISK; and I (or on behalf of my minor child), FOR MYSELF, AND ON BEHALF OF MY HEIRS, ASSIGNS, and NEXT OF KIN, HEREBY RELEASE, HOLD HARMLESS and PROMISE NOT TO SUE STAFFORD FIELD HOCKEY, THE SFH AND THEIR OFFICERS, OFFICIALS, AGENTS AND/OR EMPLOYEES, VOLUNTEERS, WITH RESPECT TO ANY AND ALL SUCH INJURY, PARALYSIS, DISMEMBERMENT, DEATH and/or LOSS or DAMAGE (EXCEPT THAT WHICH IS RESULTANT OF GROSS NEGLIGENCE and/or WILLFUL OR WANTON MISCONDUCT.)

I certify that (or on behalf of my minor child,) to the best of my knowledge, I am in good physical condition and have no disease or injury that would impair my performance or result in my being injured during any program participation.

In addition, I (or on behalf of my minor child,) do hereby consent to emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of the above named athlete/coach/child, by a Certified Athletic Trainer, Physician and/or hospital in the event of an injury or illness during the periods of time in which they are participating in a Stafford Field Hockey program. It is understood that all costs are my responsibility.

PARTICIPANT'S SIGNATURE: _____ DATE: _____

PARTICIPANT'S NAME (Print): _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

(Required if participant is Under-18)