Please complete relevant information and Safe in Care Forms.

Submit both with payment

|  |  |
| --- | --- |
| **Player Full Name** |  |
| **Address**  |  |
| **Town** |  |
| **Postcode** |  |
| **Date of birth** |  |
| **Male/female** |  |
| **Age at 01/01/2020** |  | **Yr at School** |  |
| **School Attending** |  |
| **Contact Tel:** |  |
| **e-mail:** |  |

The above information will be used solely within the organisation of Hillhead Junior Hockey Club to allow us to set up a database, which will be used to communicate to our membership where necessary.  This information will be treated with the utmost confidentiality.

Do you have any objection to photographs of your child being published on our club website? (Please delete as applicable): YES NO

In order to ensure that children are able to play in tournaments at Windyedge and other hockey venues throughout Glasgow, we need parents to help with transport and to assist coaches. Please indicate if you are willing to help: YES NO

**FEES**

The annual fee for this season is £40.00.  On top of pitch hire and equipment costs, this fee will allow the club to register with the national governing body, (Scottish Hockey Union), and the West District, allowing your child to participate in district and national competition, freely and safely.

**METHOD OF PAYMENT:**   Cash            Cheque Card

*(Please make cheques payable to ‘****Hillhead Junior Hockey Club****’)*

The weekly fee is £5 per session, to be paid at the Sunday training.

**Player’s name:**

Emergency Contact:

|  |  |
| --- | --- |
| **Name** |  |
| **Mobile**  |  |
| **Landline**  |  |

**Please give a brief description of any Medical concerns your child may have**

**Condition:**

**Treatment:**

**Has your child had a Tetanus injection in the past 5 years?**

**Yes/No        Date:**

**If your child has any allergies, please give details:**

**Medical/Dental Authorisation:**

I, , being the parent/guardian of the above named hereby authorise the HJHC convenor, or his/her representative, to administer appropriate first aid treatment in the case of accident or medical/dental emergency.  I further authorise said person, or his representative, to arrange emergency medical/dental treatment and I agree to my son/daughter receiving emergency medical/dental treatment, including anaesthetic or blood transfusion as considered necessary by the medical authorities present.

**Signature of Parent/Guardian: Date:**

**REMEMBER TO SUBMIT THE SAFE IN CARE FORM WITH THIS REGISTRATION.**