

Counties Manukau Hockey Assn

Rosa Birch Park, Beresford Street, Pukekohe

Phone: 09 238 3120 Fax: 09 238 1387 - Email: cmha@xtra.co.nz

www.cmha.co.nz

CMHA Representative Registration Form

Form MUST be completed and returned to the CMHA office. All areas, are required to be filled in. If form is not completed, you will NOT be considered for selection

First Name Surname:

Address: _____

Date Of Birth Date: Month: Year:

Home # Work # Cellphone#

Email:

Mother / Guardian

First Name Surname

Home # Work # Cellphone#

Email:

Father / Guardian

First Name Surname

Home # Work # Cellphone#

Email:

Age Group

Please Attach COPY: Either: Birth Certificate / Passport / Photo ID

Senior Men	Senior Ladies	U18 Men	U18 Ladies	U16 Boys	U16 Girls	U13 Boys	U13 Girls	Yr 5 & 6 Boys	Yr 5 & 6 Girls
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Position/s Trying Out For: _____

Position/s Played: _____

Current Playing Level: _____

Current Fitness Level: _____

CMHA Representative Consent to Play Form

I agree to my child playing in the Counties Manukau Hockey Team for the 2010 Season

Team: _____

Date: _____

I undertake to ensure that my child will attend all practices, the Intermediate Draw games, the regional tournaments and _____ tournament and that any exemption from a practice or game will be at the team's coach. Approvals must be sought prior to the practice or game in question.

I understand that the coach may remove my child from the team if he/she misses too many practices and / or games or if there is some other good reason. All costs involved will be paid by the parent and will not be a cost to cmha.

I understand all cost involved in CMHA representative hockey and am prepared to pay all costs involved.

Signed (Parent/Caregiver) _____

Full Name of Parent/ _____

Parent/Caregiver For: _____

(Child's Name)

Date: _____

CMHA Representative Medical Form

Team:

(Please attach copies of any relevant information)

Senior Men	Senior Ladies	U18 Men	U18 Ladies	U16 Boys	U16 Girls	U13 Boys	U13 Girls	Yr 5 & 6 Boys	Yr 5 & 6 Girls

Please state any Medical Information That might be relevant:

Medication: Please record any medication that is being taken to tournament, and how and when it is to be administered:

Name and Address of Family Doctor:

Phone Number:

Consent: In the event of illness or accident, I authorise the obtaining of such medical assistance as may be required.

Community Services Card Number:

(Disclosure Optional)

Signed (Parent/Guardian/Player)

Date:
