



## **ACCEPTANCE PACKAGE**

Registration

**Pacific Coast Hockey Academy**  
Suite 207 – 1097 Langford Pkwy  
Victoria, BC  
V9B 0A5 Canada

Or

**admin@pcha.ca**

*\*Please note that parents are encouraged to make photocopies of original documents for their personal records.*



## APPLICATION FOR ADMISSION

CANDIDATES NAME:		
HOME/FAMILY ADDRESS:		
CITY:	PROVINCE/STATE:	POSTAL/ZIP:
HOME/FAMILY TELEPHONE:		HOME/FAMILY EMAIL:
DATE OF BIRTH: (MM/DD/YYYY)		CITIZENSHIP:
PROGRAM APPLYING FOR: Elite 15's		U18 Prep
CURRENT GRADE:		GRADE APPLYING FOR:
STUDENT HEALTH CARD #:		SIN/SOCIAL SECURITY #:

NAME OF FATHER/GUARDIAN:		
HOME ADDRESS:		
CITY:	PROVINCE/STATE:	POSTAL/ZIP:
TELEPHONE:		EMAIL:
CITIZENSHIP:		
NAME OF EMPLOYER:		POSITION:
BUSINESS TELEPHONE:		

NAME OF MOTHER/GUARDIAN:		
HOME ADDRESS:		
CITY:	PROVINCE/STATE:	POSTAL/ZIP:
TELEPHONE:		EMAIL:
CITIZENSHIP:		
NAME OF EMPLOYER:		POSITION:
BUSINESS TELEPHONE:		

PARENTS LEGAL STATUS:	MARRIED	DIVORCED	SEPARATED	WIDOWED
ARE PARENTS REMARRIED?	YES	NO	If yes,	
STEPFATHER'S NAME:				
STEPMOTHER'S NAME:				
WHO IS THE LEGAL GUARDIAN?	FATHER/GUARDIAN		MOTHER/GUARDIAN	
PREFERRED MAILING ADDRESS:	FATHER/GUARDIAN		MOTHER/GUARDIAN	



## STUDENT HEALTH INFORMATION

### Hospital and Medical Insurance

Personal Health #:	Family Beneficiary #:	Province:
Additional Group Coverage or Private Insurance:		Plan #
In whose name is the plan registered?		
Family Physician:	Phone #:	
Fax:	Email:	
Address:	Suite#/P.O. Box:	
City:	Postal/ZIP Code:	

### Immunization

An official copy of up-to-date record of immunizations **MUST** be attached to this form. This record can be obtained from your Department of Health, School or Family Physician.

I authorize and hereby consent that immunization can be given to my child, should it be deemed necessary:

Yes

No

Initial: \_\_\_\_\_

### Dental History

*If your child requires ongoing dental or orthodontic care, please fill out contact information of Doctor currently caring for Student.*

Dental Physician:	Phone #:
Fax:	Email:
Address:	Suite#/P.O. Box:
City:	Postal/ZIP Code:

Please provide a brief description of Dental/Orthodontic History we should be aware of:

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Optometric History

Does your child wear corrective lenses?

Yes

No

Glasses

Contact Lenses

If yes, please have your Optometrist provide the current prescription for lenses.

L20/

R20/

Date of last Examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

Optometrist:	Phone #:		
Fax:	Email:		
Address:	Suite#/P.O. Box:		
City:	Postal/ZIP Code:		

*\*Please ensure that Student has a spare pair of glasses/contacts should they require them.*

Essential Health Information

Does the Student have any health concerns (mental, physical, and emotional) that our staff should be aware of? If yes, please state them:

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Have you ever been diagnosed with any mental health or learning conditions?      Yes      No

Check all that apply:

- ADD/ADHD       Depression       Anxiety       Anger Management       Dyslexia

Other(s): \_\_\_\_\_

Are you on any medications?                      Yes                      No

If yes, what kind:

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Have you ever received counselling?

Yes

No

If yes, what for?

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***\*All Applicants must also complete and attach the included Hockey Canada Medical Information Sheet***

**Emergency Contact Information**

Name:	Phone #:
Address:	
City:	Postal/ZIP Code:
Relationship to Student:	

*\*It is PCHA policy to contact parent/guardians at the earliest opportunity in the event of serious illness or injury.*

**Consent/Waiver**

I recognize that there are inherent risks associated with participating in the game of hockey, as well as those of the off-ice training and other activities involved in the Academy.

I understand and acknowledge that the staff, employees and representatives of the Pacific Coast Hockey Academy act in the place and position of a parent or guardian of my child while my child is in attendance at the Pacific Coast Hockey Academy. Recognizing this, I authorize each or any employee of PCHA to provide my child with any medical treatment they consider to be reasonable and necessary.

I hereby consent on behalf of myself, and my child, to participate in the Pacific Coast Hockey Academy at our own risk. I understand and agree that the PCHA staff, employees, representatives or directors will not be held responsible for any and all liability, claims or causes of action that may arise, and will not be held responsible or liable for any accident, damages or loss, however caused, and agree to release Pacific Coast Hockey Academy from all claims, damages, loss and expenses which may arise as a result.

I have read and understand this waiver.

Signature of Parent/Guardian: \_\_\_\_\_

Signature of Student Applicant: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Witnesses Name: \_\_\_\_\_

Date: \_\_\_\_\_