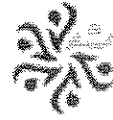


# Hockey 4 All Registration Form



inclusionwa

enriching communities through  
inclusive sport and recreation

**Venue:** Field 2, Perth Hockey Stadium, Hayman Road, Bentley

**Cost:** \$10 per session or \$60 for all 6 sessions

**Dates/Times:** 11<sup>th</sup>, 12<sup>th</sup> & 13<sup>th</sup> and 16<sup>th</sup>, 17<sup>th</sup> & 18<sup>th</sup> January 2012

**Times:** Program commences at 10am finishes at approx. 12 noon (depending on temp on days)

**Age:** For young people with a disability aged 12 – 30 years and their siblings of any age.

Please complete and return with cheque to:  
PO Box 1090, BENTLEY, MDC, WA 6983  
One Registration Form must be completed for each player.

***Please note: Instructors are responsible for instruction and group supervision. Carer support may be required for participants requiring one to one assistance with activities or equipment. Parents/Guardians and encouraged to stick around for the duration of the session.***

## Player Details:

First Name: _____	Surname: _____
Address: _____	Suburb: _____ Post Code: _____
Date of Birth:     /     /	Gender:   M / F     School: _____
Age at January 1 <sup>st</sup> 2012: _____	

**Medical Form – To Be Completed by Parent/Guardian**

***Please note: this information will assist us to include and support all participants in our programs, and that all information provided on this form is strictly confidential.***

**Participant Details:**

Given Names: \_\_\_\_\_ Surname: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Private Health Insurance Provider: \_\_\_\_\_ Ambulance Cover: **Y / N**

GP (Doctor): \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact (Name): \_\_\_\_\_

Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_ Mob: \_\_\_\_\_

Current Medication: \_\_\_\_\_

Purpose (eg. Anticonvulsants): \_\_\_\_\_

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

<b>Item:</b>	<b>Comments/Description:</b>		
If your child has a disability what is your child's primary diagnosis? Please describe:			
Does your child have any of the following conditions:	Please circle Y/N. If Y please give further information on how the condition is managed/controlled.		
Asthma	Y	N	
Diabetes	Y	N	
Epilepsy	Y	N	
If uncontrolled, please specify 1. Type of attack or seizure 2. Frequency 3. Prior warning 4. Timeframe 5. Reaction/Recovery			
Does your child have any allergies?	Y	N	<b>Comments/management</b>
<b>Mobility:</b> Does your child require any mobility aides?	Y	N	<b>Details/Specify:</b>
Is there any set procedures for transferring your child / assisting with their mobility:	Y	N	

<b>Communication:</b>	Y	N	Details / Specify?
Does your child require any assistive devices? (Eg glasses, hearing aides)			
Is your child able to follow verbal instructions?	Y	N	
How does your child communicate?			
Can your child communicate their feelings and ideas?	Y	N	
How do they respond when corrected?			
Is there anything else you can tell us about communicating with your child?			
<b>Behaviour:</b>			
How would you describe your son/daughter's behaviour? (E.g., inquisitive, withdrawn, active?)			
How do they respond when surrounded by children they don't know?			
Does your child enjoy group activities?	Y	N	
Does your child ever present with difficult or inappropriate behaviour?	Y	N	
Is there anything else you can tell us about the behaviour management of your child?			
If your child is upset, how do you manage this?			

**Other Information:**

Please indicate other information that you feel is relevant to the coaches / instructors to enable them to assist you / your child to gain the maximum benefit from their involvement in the programme.

\_\_\_\_\_

\_\_\_\_\_

Name: (Participant): \_\_\_\_\_ Signed: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_ Signed: \_\_\_\_\_

**(All information is strictly confidential)**

**Parents Details**

Names: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_ Occupations \_\_\_\_\_

*IT'S UP TO PARENTS like YOU to provide the best available management and support for your children, their team and the sport they choose to play.*

**Team Support. I would like to:** Coach  Assistant Coach  Manager  Umpire

**GRADE: Hockey 4 All - AMOUNT OF FEE PER PLAYER**

**\$60 for all sessions (or \$10 per session)**

*\*Please make cheques payable to "Hockey WA"*

*\*Please fill out the following to pay by credit card.*

**Return with cheque or card details fill in to:**

**PO Box 1090, BENTLEY, MDC, WA 6983**

**Reminder - One Registration Form must be completed for each player.**

**METHOD OF PAYMENT**

Please find enclosed a cheque/money order made out to Hockey WA for the **TOTAL AMOUNT DUE**

Please debit my Credit Card for the **TOTAL AMOUNT DUE** (plus 1% surcharge on all credit card transactions)

Credit Card Number \_\_\_\_\_

Card Type VISA / MASTERCARD Expiry Date \_\_\_\_\_

Cardholder's Name Cardholder's Signature \_\_\_\_\_

I have transferred the **TOTAL AMOUNT DUE** to the Hockey WA Account

BSB Number 036037 Account Number 163174 Receipt Number \_\_\_\_\_

Reference \_\_\_\_\_