



Blind River **BEAVERS**

Player Application

Fax: (705) 356-5596

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Applicant Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City Prov. / State Postal / ZIP Code

Home Phone: _____ Alternate Phone (cell): _____

Email: _____

Facebook Address: _____ Twitter: _____

DOB _____ Age: _____ Height: _____ Weight: _____ Citizenship: _____
as of Dec 31 this year *Canadian American*
MMM/DD/YYYY

Do you have a passport or other approved WHTI identification that is valid until after May of next year? Yes No
Have you been charged or convicted of an offense that would prevent entry into the United States? Yes No
Have you ever been detained, searched, charged or denied entry by the Canada Border Service Agency? Yes No

Primary Contact - Financial and Emergency Medical

Relationship to applicant _____ Primary Phone: _____

Name: _____
Last First

Address: _____
Street Address Apartment / Unit #

City Prov / State Postal/ Zip Code

Alternate Phone: _____ Email Address: _____

Hockey Information

Do you have a Player Representative / Family Advisor? If yes Name: _____ Phone: _____

Email: _____ Cell Phone: _____

Last Team: _____ League: _____ Level: _____

GM Name: _____

GM Phone #: _____ GM Cell Phone #: _____

Position: (C, Wing, D, G): _____ Shoots / Catches: Left Right

Stats: Player: _____
GP G A Pts +/- PIM

Goalie: _____
GP W L T SO GAA S%



Medical Information

All information collected on this form is for the strict use of our trainers and any medical establishment/personnel that are required to provide medical care to the player named above. This information will not be shared with anyone else and it will be destroyed at the end of the season.

Current Medications:

Current vaccinations & dates:

		YES	NO			YES	NO
1.	Are you currently under the care of a physician?			Were metal pins, screws or other devices put into your bones to help heal?			
2.	If "yes", where and for what reason? _____ _____			16.	Do you have or have had:		
3.	Have you been hospitalized in the previous				Asthma		
a.	12 months?				Diabetes		
4.	If "yes", where and for what reason? _____ _____				Hepatitis		
5.	Do you have any allergies?				convulsions/seizures		
	If "yes", what are they? _____ _____				infectious mononucleosis		
6.	Do you have any food allergies?				viral pneumonia		
	If "yes", what are they? _____ _____				chickenpox		
7.	Do you have any drug allergies?				mumps		
	If "yes", what are they? _____ _____				measles		
8.	Have you ever had a concussion, been knocked out or fainted?				other infectious disease		
	How many times: _____				hemophilia		
	Were you under a doctor's care?				high blood pressure		
	Explain: _____ _____				kidney disease		
	Last occurrence: _____ Were you hospitalized?				heart trouble		
9.	Do you wear glasses?				epilepsy		
10.	Do you wear contacts?				attention deficit/hyperactivity		
11.	Do you wear contacts while participating in sports?				rheumatic fever		
12.	Do you wear any supports or braces while participating in sports?				arthritis or other degenerative diseases		
13.	Do you smoke or use tobacco products?				Any other? _____ _____		
14.	Do you experience back pain?						
	If "yes", how often?						
	Seldom occasionally after exercise after lifting						
15.	Have you broken any bones?						
	If "yes", where and when: _____ _____						

Medical Insurance

Photocopy both sides of Ontario Health Card or supplemental insurance here.



Questions

Tell us why you should be a member of our team:

Please state what you hope to achieve from playing junior hockey

Please state the best hockey advice given to you:

Please state what other sports you currently play, or have interest in:

If chosen as a member of our team, will you have a vehicle at your disposal during the entire playing season?

Additional comments you might have:

If you have any other information that is pertinent to this application, please attach it to this document.

I hereby certify that all information above to be true:

Player signature: _____