THE CATHOLIC ACADEMY OF STAMFORD

LOWER CAMPUS
1186 Newfield Avenue
Stamford, Connecticut 06905
203-322-6505 FAX: 203-595-0858

UPPER CAMPUS
948 Newfield Avenue
Stamford, Connecticut 06905
203-322-7383 FAX: 203-322-4435

Sports Registration

A valid medical examination form is also required to participate and must be on file in the Nurse's Office. Medical forms are available from the school nurse.

Player's Name _____

Date of Birth _____

Home Phone # _____

Parent's/Guardian's Names _____

Home Address _____ _____

Emergency Phone # _____

Parent emails _____

USA Hockey Number _____

Liability Waiver

I grant permission for _____ to participate in the Catholic Academy of Stamford Hockey Program. I represent that this child is in satisfactory health to participate in the required activity, and I hereby release the Catholic Academy of Stamford, the Bridgeport Diocesan Schools Corporation, including officers, teachers, administrators, and coaches from liability for any health or injuries which may result from these activities. I/we understand that participation in or observation of the sport of hockey constitutes a risk to me/us of injury, including without limitation paralysis or death. I/we voluntarily recognize, accept and assume these risks and release and agree to hold harmless the Catholic Academy of Stamford, the 2017-2018 organizers, officials, coaches, their officers and other representatives from any liability, suits, action, claims, costs, expenses (including medical and legal expenses), damages, losses of any nature now or later arising out of or directly or indirectly related to participation, observation, presence by anyone, in, of, or at the sport or related to activities, or medical treatment or procedure arising out of any of the above.

Permission for Medical Treatment

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel designated by the Catholic Academy of Stamford coaching staff to attend to my son/ daughter. Name_____

I expect that every effort will be made to contact me in order to receive my specific authorization before any further treatment or hospitalization is undertaken.

Date _____

Signature of Parent/Guardian_____