



## REGISTRATION / MEDICAL FORM

SHOOT TO SCORE CLINIC 2021  
Top Shelf Ice Arena, Gurnee, IL  
(Dec 29 & 30th)  
2021-22 TRAVEL GOALIES (A, AA, AAA), H/S

\_\_\_\_\_ 1 Day Cost (\$40) – which day will you be attending? \_\_\_\_\_  
\_\_\_\_\_ 2 Day Cost (\$75)

*Please fill this form out completely.*

GOALIE

NAME: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_  
No. Street City State Zip

Main Contact Phone Number: \_\_\_\_\_

Parent's Contact Number  
(u18): \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

2021-22 Team and Level of play: \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency contact #2 \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Health Background:**

Please provide any important information regarding you or your child's health, and past medical information or history and medications being taken. This will help us to be better informed in case of an emergency. (E.g. allergies, asthma, concussions, surgery, etc...)

---

**No food or water will be provided, please bring your own if needed.**

**Medical Insurance Information:**

Company Name: \_\_\_\_\_  
Company Address: \_\_\_\_\_  
Insurance Co. Phone: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_  
DOB# of Insured: \_\_\_\_\_  
Employer of Insured: \_\_\_\_\_

**Medical Treatment Authorization and Liability Release**

I, the undersigned acknowledge that I am the parent or guardian of \_\_\_\_\_, and do hereby grant my permission for my hockey player to attend P.A.D.S. School of Goaltending, LLC. Shoot to Score Clinic 2021 and to actively and fully participate in all activities thereof. In the event of an injury or illness during these activities, my signature indicates that I agree to allow medical treatment even if I cannot be contacted, and authorize P.A.D.S. School of Goaltending, LLC and /or the local hospital to provide the needed medical treatment they deem necessary.

I hereby release Roy J. Perfetti, and all members of the program's staff, the host ice facility and its staff, the local hospital and their doctors, agents, employees, and representative and all officers of P.A.D.S. School of Goaltending, LLC. & Herbster Hockey from any and all claims and liabilities arising in any way out of its exercise of this authority. I understand and agree that all bills for any medical/dental care and treatment will be forwarded to me, or my insurance company, and that it will be my responsibility to see that such bill are paid in full.

I further acknowledge, understand, and agree that in participating in this activity there is a possibility of physical illness or injury and that I, as a parent or guardian of my hockey player am assuming the risk of such injury by his/her participation and release the staff, the host rink, its staff and all affiliated with or participating in the P.A.D.S. School of Goaltending, LLC. & Herbster Hockey Programs from all liability, claims, obligations or responsibility for personal property losses, accidents or injuries of any kind.

I have received a copy of the schedule and understand the activities. I understand that full, legal equipment is to be worn properly at all times on the ice or bench.

---

Parent-guardian's signature and relationship with participant (under 18) \_\_\_\_\_ Date \_\_\_\_\_

---

Hockey player's signature (if over 18) \_\_\_\_\_ Date \_\_\_\_\_

**Please fill out this form, save to your desktop and email back to us to secure your spot first. Email registration form: [roy@padsgoaltending.com](mailto:roy@padsgoaltending.com) or mail:**

**P.A.D.S. School of Goaltending, LLC.**

**PO Box 705**

**Lake Zurich, IL 60047**

**We accept cash, checks, CC, Zelle, and Venmo. Payment can be mailed to us or the balance of the payment will be accepted at the rink.**