2015-16

Bluegrass Premier Indoor Registration Information

Section I: Athlete Information

Name: _____ I Prefer to be called: _____

Address: _____ City: _____ State: _____Zip: _____

Date of Birth: _____ USA Field Hockey ID Number: _____ Bluegrass Uniform #: _____
(Please include a copy of your USFHA Card if available)

YOU MUST HAVE CURRENT USA FIELD HOCKEY MEMBERSHIP TO PARTICIPATE IN ANY SESSION (THIS IS REQUIRED BY USA FIELD HOCKEY)

Position: _____ Player Cell Phone: _____

Name of School: _____ Player Email: _____

Section II: Payment Information **Date_____**

Individual Sign-up Age Group (Check one):

- ☐ **U-19** $485.00
- ☐ **U-16** $485.00
- ☐ **U-14** $485.00
- ☐ **U-12** $250.00
- ☐ **Goalkeepers** $485.00

One session with age group and one with GK's only.

Age Group: _____

Payment Method: _____

Are you willing to travel if invited?
☐ Yes, I am willing to travel.
☐ No travel, please.

Payment Instructions:
Make checks payable to:
Bluegrass Premier FHL, LLC - PO Box 34481
Louisville, Kentucky 40232-4481

Credit Cards NOW ACCEPTED
___Credit Card: VISA, MC, and AMEX

Amount Authorized: _____

Name on Card: _____

Card Number: _____

Exp Date: _____ CIV Code: _____

Signature: _____
By signing above, you are authorizing Bluegrass to charge your credit for the amount listed above. All credit card information is confidential and protected.

Section III: Responsible Party and Emergency Contact Information

Relationship to Athlete: ☐ Parent ☐ Guardian ☐ Other:_____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Bluegrass Premier Indoor Registration Information

Section IV: Health Concerns

_____

_____

_____

_____

_____

_____

_____

Section V: Health Insurance Information

Name of Insured_____DOB_____Relationship to Athlete _____

SSN#: _____ Name of Employer: _____ Work Phone: (____)_____

Address of Employer: _____City: _____ State: _____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address: _____ Ins Co. Phone:
_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Athlete _____

SSN#: _____ Name of Employer: _____ Work Phone: (____)_____

Address of Employer: _____ City: _____State: _____Zip _____

Insurance Company: _____ Grp #: _____ ID#: _____

Ins Co Address: _____ Ins Co. Phone: _____