

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:

- | | |
|-------------------------------|----------|
| <input type="checkbox"/> U-19 | \$535.00 |
| <input type="checkbox"/> U-16 | \$535.00 |
| <input type="checkbox"/> U-14 | \$535.00 |
| <input type="checkbox"/> U-12 | \$300.00 |

Age Group? _____

Payment Method: _____

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

Credit Cards Accepted: VISA, MASTER CARD, AMERICAN EXPRESS

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: _____ Phone: (____) _____

Email Address: _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

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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: _____