Bluegrass Premier Spring Registration Information 2018

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:

☐ **U-19**	$530.00
☐ **U-16**	$530.00
☐ **U-14**	$530.00
☐ **U-12**	$300.00
☐ **U-10/U-8**	$300.00
☐ **Goalkeepers**	$530.00

$575 if post-marked or emailed after March 10th.

Refunds are only issued due to a medical issue or Injury. A note from your medical provider along With your written request must be submitted Within 14 days of the injury/illness.

Payment Instructions
Make checks payable to:
Bluegrass Premier Field Hockey Club
1102 Clerkenwell Road, Louisville, KY 40207

Credit Cards Accepted: VISA, MASTER CARD, AMERICAN EXPRESS
Amount Authorized _____

Name on card _____

Card Number _____

Exp Date: _____

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 (_____)_____

Bluegrass Premier Spring Registration Information

Section IV: Health Concerns

_____

_____

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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:_____