

# VAIL Mail-in Registration Form

Mail to:

Bob Johnson Hockey School  
Dobson Arena  
321 E. Lionshead Circle  
Vail, Colorado 81657  
970-479-2271 fax: 970 479-2197

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age as of (7/20/10) \_\_\_\_\_ Position \_\_\_\_\_ Hockey Experience (years) \_\_\_\_\_

Applicant's Medical Coverage \_\_\_\_\_

Payment Method: Check # \_\_\_\_\_ Make checks payable to John Dobson Ice Arena Visa \_\_\_\_\_ MasterCard \_\_\_\_\_

Card Number \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name on Card \_\_\_\_\_ Signature: \_\_\_\_\_

Session- July 19 <sup>th</sup> - July 25 <sup>th</sup> (7 days)	@ \$445.00=\$ _____
*Session- July 19 <sup>th</sup> - July 25 <sup>th</sup> (7 days) Special Eagle Valley Resident Discount	@ \$420.00=\$ _____
*Session- July 19 <sup>th</sup> - July 25 <sup>th</sup> (7 days) Special Vail Resident Discount	@ \$400.00=\$ _____
Session (Special Goalie Rate)	@ \$175.00=\$ _____

Amount Due (balance due by June 20, 2010) =\$ \_\_\_\_\_

Participant's Name \_\_\_\_\_

## RELEASE OF LIABILITY/ACKNOWLEDGEMENT OF RISK

Upon entering events sponsored by the USA Hockey and/ or its member districts, I/We agree to abide by the rules of USA Hockey as currently published. I/We understand and appreciate that participation or observation of the sport constitutes a risk to me/us of serious injury, including permanent paralysis or death. I/We voluntarily and knowingly recognize, accept, and assume this risk and release USA Hockey, its Affiliates, The Bob Johnson Hockey School, and/or its representatives, City of Aspen, their sponsors, event organizers and officials from any liability therefore.

*\*READ ABOVE BEFORE SIGNING*

Participant's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Parents or guardian's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

## MEDICAL TREATMENT RELEASE

Authorization for necessary medical treatment during absence of parent or legal guardians. I acknowledge that necessary medical care may be administered to \_\_\_\_\_

During my absence or in the event I cannot be reached immediately. The Vail Valley Hospital and /or any designated physician are authorized to perform this treatment.

Signature of Parent/Guardian \_\_\_\_\_ Date Signed: \_\_\_\_\_