VAIL Mail-in Registration Form

Mail to:
Bob Johnson Hockey School
Dobson Arena
321 E. Lionshead Circle
Vail, Colorado 81657
FAX: 970 479-2267
Phone: 970-479-2271

Name:____

Address:____

City, State, Zip:_______________________________________

Email:____

Birth date:_________ **Age as of (7/18/09)** ______ **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- July18- July 24	**$445.00= $**_____________
*** Special Eagle County Resident Discount**	**$420.00= $**_____________
*** Special Vail Resident Discount**	**$400.00= $**_____________
*** Special Goalie Rate**	**$175.00= $**_____________

Amount Due (balance due by June 15, 2009)= $_____________

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:**_________