2025-2026 Season Sled Hockey Application Form

Thank you for your interest in our sled hockey program. Please carefully complete all sections of this application. The information provided will be kept confidential, used solely for the purpose of ensuring the safety and well-being of all participants.

Personal Information

- Full Name: _____
- Date of Birth: _____ / _____ / _____
- Gender: _____
- Address: _____
- City: _____ State:_____ Postal Code: _____
- Phone Number: (_____) _____-_____
- Email Address: _____
- Parent/Guardian Name (if under 18): _____
- Relationship to Participant: _____
- Parent/Guardian Phone: (_____) _____-_____
- Parent/Guardian Email: _____

Emergency Contacts

Please provide at least one emergency contact.

- Emergency Contact 1:
- Name: _____
- Relationship: _____
- Daytime Phone: (_____) _____-_____
- Evening Phone: (_____) _____-_____
- Email: _____

Additional Contact (optional):

- Name: _____
- Relationship: _____
- Phone: (_____) _____-_____
- Email: _____

Emergency Action Plan

- Are there any special instructions in case of a medical emergency? Yes / No
- If yes, please detail:
  _____

Medical Conditions

DO YOU HAVE ANY OF THE FOLLOWING?;

MEDICATION ALLERGIES	YES	NO	
ASPIRIN, IBUPROFEN, ACETAMINOPHEN,CODINE	YES	NO	
PENICILLIN	YES	NO	
SULFA	YES	NO	
LOCAL ANESTHETIC	YES	NO	
LATEX	YES	NO	
OTHER	YES	NO	
HEART PROBLEMS	YES	NO	
ARTIFICIAL HEART VALVE OR STENT	YES	NO	
PACEMAKER	YES	NO	
HIGH OR LOW BLOOD PRESURE	YES	NO	
STROKE OR BLOOD THINNERS	YES	NO	
ANEMIA OR BLOOD DISORDER	YES	NO	
PROLONGED BLEEDING (INR>3.5)	YES	NO	
EMPHYSEMA, SHORTNESS BREATH	YES	NO	
ASTHMA	YES	NO	
KIDNEY, THYROID OR LIVER DISEASE	YES	NO	
DIABETES, TYPE I or II	YES	NO	
ARTHRITIS	YES	NO	
GLAUCOMA	YES	NO	
HEAD OR NECK INJURIES	YES	NO	
EPILEPSY, CONVULSIONS (SEIZURE)	YES	NO	
NEUROLOGIC DISORDERS	YES	NO	
RADIATION OR CHEMOTHERAPY	YES	NO	
IMMUNOTHERAPY	YES	NO	

ANY OTHER MEDICAL NOTES:

Medications

Please list all medications and reasons for medication

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Additional Information (Optional)

- Previous experience with sled hockey or other adaptive sports:
  _____
- Goals or expectations for participating in the program:
  _____
- How did you hear about the program?
  _____
- Do you require any equipment or support to participate fully?
  _____
- Other comments or concerns:
  _____
  _____

Consent and Waivers

- Participation Consent: I, the undersigned, consent to participate in the sled hockey program organized by Chautauqua County Sled Stars. I acknowledge the risks involved in sled hockey, including but not limited to physical injury, and agree to follow all safety instructions provided by the coaching staff.
- Medical Release: In the event of a medical emergency, I authorize program personnel to seek emergency medical treatment on my behalf or on behalf of my child/dependent. I certify that all medical information provided is accurate to the best of my knowledge.
- Photography & Media Release (optional): I grant permission for photographs or videos taken during program activities to be used for promotional purposes by Chautauqua County Sled Stars unless otherwise indicated in writing.
- Privacy Statement: All information provided will remain confidential and will be used solely for program administration, safety, and emergency response.

Participant Signature: _____ Date: ____ / ____ / _____

Parent/Guardian Signature (if under 18): _____ Date: ____ / ____ / _____

Submission Instructions

Please return completed forms by email to: COACHK.CCSS@GMAIL.COM or deliver in person to 319 W. 3RD STREET JAMESTOWN, NY 14701. If you have any questions, contact KATHLEEN MUELLER at 716-720-8623 or COACHK.CCSS@GMAIL.COM.

Thank you for your interest in sled hockey. We look forward to welcoming you to the team!