

NAME OF PLAYER \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_ TOWN \_\_\_\_\_ ZIP CODE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ GOALIE (circle one) YES NO

PRIMARY EMAIL ADDRESS \_\_\_\_\_

PARENTS SIGNATURE \_\_\_\_\_

**PARENTS: PLEASE INDICATE IF YOU ARE INTERESTED IN ANY OF THE FOLLOWING (circle).**

**HEAD COACH      ASSISTANT COACH      REFEREE**

**FEE IS \$100.00 PER PLAYER (\$75 FOR 4/5/6 CLINIC & 7/8/9 DIVISION)**

\$250.00 FOR 3 (brothers and/or sisters only)

\$300.00 FOR 4 (brothers and/or sisters only)

**MAKE ALL CHECKS PAYABLE TO JOHN J. McMAHON JR. MEMORIAL ROLLER HOCKEY CLUB, INC.  
MAIL FORMS AND CHECKS TO:**

**John J. McMahon Roller Hockey  
P.O. BOX 2586  
NORTH BABYLON, NY 11703**

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