FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

SWIM TEAM REGISTRATION

Participant Information

Name____ DOB ___________________

Male/Female (Circle One) Age___________

Ethnicity (optional):______________________________

Address____

City/State/Zip____

Home Phone___________________________ Cell Phone_____________________

Email____

Emergency Contact____

Gold (Advanced)	M-F	3:30-5:30pm	$55/month	________
Silver (Intermediate)	M-W-F	3:30-5:30pm	$45/month	________
Bronze (Beginner)	T-TH	4:30-5:30pm	$35/month	________

* A $10 late fee will be applied if monthly fee is not paid within 25 days of that month.

Consent for Medical Treatment:

As the parent or legal guardian of the above named participant, I hereby give my consent for emergency medical care prescribed by a duly licensed physician. The care may be provided under whatever conditions necessary to preserve the well -being of my participant.

Parent/Legal Guardian Signature:____

(Oct. 2018)