

MERCED SKIMMER SWIM CLUB REGISTRATION AND MEDICAL AUTHORIZATION

First Swimmer's Information

(Last Name) (First Name) (Middle Initial) (Gender M/F)

(Address) (City & Zip Code) (Phone Number)

(Birth Date) (Grade in School) (School Name) (Group: Gold, Silver, Bronze)

Second Swimmer's Information

(Last Name) (First Name) (Middle Initial) (Gender M/F)

(Address) (City & Zip Code) (Phone Number)

(Birth Date) (Grade in School) (School Name) (Group: Gold, Silver, Bronze)

Third Swimmer's Information

(Last Name) (First Name) (Middle Initial) (Gender M/F)

(Address) (City & Zip Code) (Phone Number)

(Birth Date) (Grade in School) (School Name) (Group: Gold, Silver, Bronze)

PARENT'S INFORMATION

(Father's First & Last Name) (Mother's First & Last Name)

(Father's Occupation & Work Number) (Mother's Occupation & Work Number)

Billing Address Information (If Different From Above) (City & Zip Code)

(Father's Email Address) (Mother's Email Address)

I wish to have my personal contact information published in the team directory: Yes___ No___

Note: The above information will be used for billing and roster preparation. Additionally, I, undersigned, understand that monthly membership dues, family assessment hours, and fees continue to be payable each month until written notice is given of withdrawal of the swimmer(s) of the Merced Skimmer Swim Team Treasurer at P.O. Box 2746 Merced, CA 95344.

EMERGENCY MEDICAL INFORMATION

(Physician's Name) (Physician's Phone Number)

(Insurance Provider Name & Policy Number)

EMERGENCY MEDICAL AUTHORIZATION

I, _____, have legal custody of _____, and grant permission for any treatment and/or hospital services that may be rendered to said minor(s) under general or specific direction of Dr. _____, telephone _____, or any hospital department physician when I cannot be contacted for specific permission and while my child is under the control of the Merced Skimmers Swim Team.

(Signature of Responsible Party, Parent, or Guardian)

(Date)