

BELLEFONTAINE SWIM TEAM REGISTRATION

2010

NAME: _____ /_____/_____
(last name) (first name) (date of birth)

ADDRESS: _____
(street) (city) (zip code) (telephone)

SWIM TEAM EXPERIENCE: _____

Have you or are you taking swimming lessons? _____(yes/no)

If yes, what swim level did you last complete? _____

**Swim team is open to all Logan County residents age 6-18, however, you must be able to swim a length of the pool, 25 yds., for 7-9 yr. olds; 2 lengths of the pool, 50 yds for 10-18 yr. olds, Freestyle. **Although failure in the above area does not prevent a child from being on the swim team and attending practice. It is understood the coach's responsibility will be to provide stroke evaluation, improve mechanics, and some correction. The coach cannot, due to time constraints, teach the child how to swim--this is the swimmer and parents responsibility.

Having been informed of the organization the Bellefontaine Swim Team will provide supervised swim meets for boy/girls, I/we, the parents of the above named swimmer do hereby give my/our approval to participate in any and all of the activities, during the current season. I/we do assume all risks and hazards incidental to the conduct of the activities, transportation to and from the activities; and I/we do further hereby release, absolve, indemnify and hold harmless the Bellefontaine Swim Team, and the Bellefontaine Joint Recreation District, and the organizers, sponsors, supervisors, any and all of them.

I/we, the parents of the above named swimmer, do understand all of the above, and I/we will furnish a certified copy of the above named candidate's birth certificate to the Swim Team officials, if necessary.

Parent/Guardian

Signature _____ Date _____

Please check an area that you would like to work or learn how to do.

___Timer___Scorekeeper___Ribbon writer___Set-up___Runner___Concession___Judge

PARTICIPATION FEE: \$35.00 – No refunds _____ PAID

Emergency Medical Authorization

Bellefontaine Parks & Recreation Department:
Student's Name _____
Address: _____ City: _____
Telephone: _____ School attended during 08/09 year: _____

Purpose: To enable parents and guardians to authorize the provisions of emergency treatment for children whom become ill or injured while under Park authority, when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED

Part I – TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (Phone) or _____
(other parent or guardian) at _____ (Phone) have been unsuccessful, I hereby give my
consent for (1) the administration of any treatment deemed necessary by Dr. _____ (preferred Dr.)
at _____ (Dr. address & phone), Dentist _____ (phone &
address) _____ or (2) in the event the need to transfer the child
to _____ (preferred hospital) or any hospital reasonable and accessible. This
authorization does not cover major surgery unless the medical opinion of two other licensed Doctors or
Dentists, concurring in necessity for such surgery, are obtained prior to the performance of such surgery.
Facts concerning the child's medical history including allergies, medications being taken, and any other
physical impairments to which a physician should be alerted:

Date: _____ Signature or Parent or Guardian: _____

Address: _____

PART II – REFUSAL TO CONSENT (Do not complete PART II if you completed PART I)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the Park Authorities to take no action or to: Specific instructions: _____

Date: _____ Signature of Parent or Guardian: _____

Address: _____