



CFYN Tigersharks USA Swim Team

Registration & Medical Release Form



SWIMMER INFORMATION

Last _____ First _____ MI _____ Nickname _____

Address _____ City _____ State _____ Zip _____

Age : _____ School _____ Birth _____ Gender _____
 Grade _____ Date _____

Main contact
 EMAIL: _____

EMAIL 2: _____

PARENT OR GUARDIAN INFORMATION

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Have you ever registered for USA swimming before? If yes, what team _____

Administrative fee One time per year/family	\$10
USA Swimming Yearly Membership (only for those without current USA Membership) Spring/Summer Session Only (only for those without current USA Membership)	\$27.50
Summer Season CFYN swimmer	\$80
SLCC member	\$60
Non CFYN swimmer	\$100
Total Enclosed – Check Payable to CFYN	

Please return this form, along with your check to:

CFYN Summer Long Course
 PO Box 49
 Cuyahoga Falls, OH 44222
 Due May 25th



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SWIMMER INFORMATION

Last _____ First _____ MI _____ Nickname _____
 Address _____ City _____ State _____ Zip _____
 Age : _____ School _____ Birth _____ Gender _____
 Grade _____ Date _____

RESIDENTIAL PARENT OR GUARDIAN:

<u>Name</u>	<u>Home Phone</u>	<u>Work Phone</u>	<u>Cell Phone</u>

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I HERBY GIVE CONSENT FOR THE FOLLOWING PROVIDERS AND LOCAL HOSPITAL TO BE CALLED:

Physician _____ **Phone** _____
Dentist _____ **Phone** _____
Alt Emergency _____ **Phone** _____
Contact (Non Parent) _____ **Phone** _____
Local Hospital _____ **E/R Phone** _____

In the event reasonable attempts to contact me have be unsuccessful. I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors or in the event the designated preferred practitioner is not available, by another licensed physician or dentist and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery, unless the medical opinions of two licensed doctors or dentists, concurring in the necessary for such surgery, are obtained prior to the performance of such surgery. Please list facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted in the box below. Use back of sheet if necessary.

MEDICAL CONDITIONS: MEDICATIONS: none
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Signature of Parent or Guardian

Date

PART II: REFUSAL TO CONSENT

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I want the following action. Use back of sheet if necessary.

Signature of Parent or Guardian

Date