2017 CFYN LONG COURSE PROGRAM
REGISTRATION AND EMERGENCY MEDICAL FORM

Last Name:_____First Name:_____MI_____

Address:_____City:_____Zip:_____

Age:_____ Birth Date:_____/_____/_____ Gender (circle one): Male Female

Did you swim for Tigersharks in the 2016/2017 short course season? (circle) Yes No

T-shirt Size _____

Circle the price of the program(s) you are signing up for.

Please note these are the only options available, we will not be able to prorate fees based on late starts or due to vacations. ***All swimmers*** *are required to be registered USA Swimming members.*

Program	Cost	Booster Subsidy *	Subsidized Cost
Spring & Summer Program	$490	(-100)	$390
Spring Only	$135	(-25)	$110
Summer Only	$375	(-75)	$300
Spring Dryland -Optional Add-on (YMCA membership required)	$15	N/A	N/A
Spring Stroke Clinic (Beginner – Age Group 3)	$65	$15	$50
USA Registration (does not apply to swimmers who are already registered with USA swimming)	$45.00	N/A	N/A

**** Subsidy applies ONLY to swimmers whose immediate family had a Tigershark registered in the 2016/17 Short Course season and the family participated in the fundraising efforts.***

Total Cost: _____ Payment Plan? (circle) Yes N

Payment Plans:

For the Spring & Summer combo program program we will offer payment plans dividing the cost into 3 equal monthly payments. 1st payment due at registration, second payment on May 1st, and third payment on June 1st.

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Parent/Guardian Information:

Mother's Name:_____Phone:_____

Address:_____City:_____Zip:_____

Father's Name:_____Phone:_____

Address:_____City:_____Zip:_____

Primary e-Mail:_____ Secondary e-mail:_____

Emergency Information:

Emergency Contact:_____Phone:_____

Physician's Name:_____Phone:_____

Preferred Hospital Name:_____Phone:_____

List any medical conditions/medications:_____

LIABITLITY WAIVER AND CONSENT FOR MEDICAL TREATMENT

In the event reasonable attempts to contact me have been un-successful, 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 reasonable accessible. The 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 .

Club Official Use Only

☐ Total fees owed _____

☐ Escrow Deposit _____

Total Received: _____

Check Number/Cash _____

_____ _____

(Signature of Parent/Guardian) (Date)

***Return form to Coach Dale or PO Box 49, Cuyahoga Falls, Ohio 44222**