

**2013 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

Choose your practice options:

_____ 3 Days per week \$200 (Spring & Summer M, W, Th)

_____ Extra add on day of Practice \$50 (Summer only, Tuesdays)

_____ 1 Day per week only \$100 (Summer only, Tuesdays)

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: _____

Dentist's Name: _____ Phone: _____

Preferred Hospital Name: _____ Phone: _____

List any medical conditions/medications: _____

LIABILITY WAIVER AND CONSENT FOR MEDICAL TREATMENT

In the event reasonable attempts to contact me have been 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 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	
<input type="checkbox"/> Total fees owed	_____
<input type="checkbox"/> 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