2015 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

Tiger Group Options	Shark Group Options
☐ **Spring & Summer** $235	☐ **Spring & Summer** $355
☐ **Spring Only** $130	☐ **Spring Only** $170
☐ **Summer Only** $130	☐ **Summer Only** $210
☐ **USA Membership** $45 (new members only)	☐ **USA Membership** $45 (new members only)
	☐ **Optional 4th Spring Practice Day ***
	☐ **Optional 4th Summer Practice Day ***
	☐ **Optional 5th Summer Practice Day ***

* Prices determined by the total cost of each day divided by the number of participants who sign up for it. See the Long Course Info Page for more info.

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**