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CFYN Tigershark Swim Team

Swimmer Information

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ Zip Code _____

Phone Number _____ Male/Female _____ Date of Birth _____

Competitive Swimming Experience

Have you ever been on a competitive swim team before? ◯ Yes ◯ No

If yes, what team(s)? Returning Tigershark ☐

Other Team(s): _____

If Returning Tigershark What Practice Group Were You In for the 2020-2021 Season?

_____

Parent or Guardian Contact Information

Mother _____ Phone _____

Father _____ Phone _____

Email _____

Swimming Program

Age Group Swimmer ◯

High School Swimmer ◯

High School Team (if applicable)

_____

T Shirt Information

No T-Shirt Desired (will not change fees) ☐

T-Shirt Size _____

Name on Back of Shirt _____

Please Leave Back Blank ☐

Acknowledgements

Please place a check in the checkbox next to the statement and initial that you have read and agree to the document or acknowledgement. For Signatures you may type your name in as it appears in the above Contact Information

- Covid-19 Guide Line ☐ _____ Initials
- Code of Conduct ☐ _____ Initials
- Lindsay's Law ☐ _____ Initials
- Volunteer/Meet Commitment Contract ☐ _____ Initials

Parent Signature _____ Date : _____

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Part I or II Must Be Completed

Part I: To Grant Consent

I hereby grant consent for the following providers and local hospitals to be called from my child listed above.

Physician		Phone	
Dentist		Phone	
Alt Contact		Phone	

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 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 and Allergies

Medications

Parent Signature: 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 medical treatment, I want the following action taken. Use back of sheet if necessary

Parent Signature: Date :