Box Elder Swim Team, Inc
Registration Form

Mailing Address: Date: ____________________
Box Elder Swim Team
PO Box 826
Brigham City Utah 84302

SWIMMER INFORMATION:

____
(Last Name) (First Name) (MI)

____
(Mailing Address) (City) (State) (Zip)

PARENT OR GUARDIAN INFORMATION:

____
(Last Name) (First Name) (MI)

____
(Address if different from above)

____
(Home phone) (Cell phone) (e-mail)

RELEASE OF LIABILITY

I acknowledge and realize there is some risk and / or danger involved with this sport, but nevertheless I release and agree to hold harmless the BOX ELDER SWIM TEAM, claims/ suits resulting from the above named swimmer's participation in the team activities.

Parent Signature: ___________________________________ Date_________________

RESPONSIBILITY FOR PAYMENT

I agree that if for any reason the above named swimmer quits the BOX ELDER SWIM TEAM, I will notify the Corporate Treasurer and the coaches, and that I will pay in full any balance due within a 30-day period or I will be subject to a service charge of $20.00 (twenty) for the collection process if it becomes necessary.

Parent Signature: ___________________________________ Date __________________

BEST REGISTRATION FORM Page #2

Release For Participation and Good Health

I do hereby give my permission for the above named swimmer to engage in team practice and I also believe that the said swimmer is in good health and able to participate in vigorous aquatic and / or dry land training. I also state that all known medical conditions, including the taking of medication, have been discussed with the team coaches. I also understand that such medical conditions may preclude or limit aquatic training with the team.

Parent Signature: ____ Date: ________________

Please list any medical conditions that coaches need to be aware of, such as asthma, diabetes, etc:

Please list any medication allergies: ____

Please list any food allergies: ____

AUTHORIZATION FOR MEDICAL AND EMERGENCY MEDICAL TREATMENT

I DO HEREBY AUTHORIZE AND GIVE MY CONSENT FOR MEDICAL, EMERGENCY MEDICAL AND /OR DENTAL TREATMENT, INCLUDING SURGERY IF DEEMED NECESSARY FOR THE FOLLOWING PERSON/SWIMMER:

(Last name) (First name) (MI)

This authorization shall extend over all official activities of the BOX ELDER SWIM TEAM, INC, such as practice sessions, swim meets and team sponsored social activities. I further agree that I will not make any claims on the behalf of the above listed swimmer for failure to obtain consent from me for medical treatment rendered by any/ all licensed physicians or institutions

Parent Signature____ Date: ________________

IN CASE OF EMERGENCY, PLEASE CONTACT

(Name) (Telephone) (Cell Phone) (Work Phone)

(Relation to swimmer)

(Name) (Telephone) (Cell Phone) (Work Phone)

(Relation to swimmer)

(Name) (Telephone) (Cell Phone) (Work Phone)

PHYSICIAN INFORMATION

Physician Name: ____________________________________ Telephone Number: __________________

INSURANCE INFORMATION

Company name:_____________________________________Policy/Group #___________________