2009- 2010 STINGRAY WINTER SWIM TEAM PARTICIPANT FORM

Swimmer Information

Name: __________________________ Age: _____ Birthdate:_________ Male or Female

Name of Parent(s)/Guardian(s):____

Address: _________________________________

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Phone

Home: _________________________________

Cell: _________________________________

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Preferred Contact Number:________________________________

E-mail Address:

Similar to winter season parents will receive information regularly through e-mail.

e-mail address: _________________________________

additional e-mail: _________________________________

Emergency Contact Information

please list contact other than the parent(s)/guardian(s) listed above

Name: _________________________________

Main Phone Number: __________________________

Cell Phone Number: __________________________

Address: _________________________________

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Swimmer Medical Information

Complete Name of Swimmer: ____________________________

To insure the safety and well being of your child please be as specific and complete as possible with any medical conditions.

Allergies: please list severity as well as type

include latex, insect, and food allergies

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Learning Conditions: *such as ADD or ADHD*

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Physical Conditions:____

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Consent:

Swimmers will be videotaped during the spring stroke clinic. This enables swimmers to see their performance in the water. This film will be reviewed by the coaching staff (Rebecca Bute) with swimmers. Your child will not be taped without your consent. Taping will take place at the beginning and closing of the stoke clinic to illustrate progress. Photographs of the stroke clinic may be taken for promotional purposes.

Do you give your consent for the videotaping of your child? __________________

Do you give consent for the photography of your child? _______________________

signature of parent or guardian: _______________________________ date: __________