WAVE SWIM TEAM SUMMER '07 REGISTRATION FORM

SWIMMER'S NAME (Last, First, Middle Initial)	BIRTHDATE	AGE AS OF 6/1/2007
1. ________________________	/ /	____
2. ________________________	/ /	____
3. ________________________	/ /	____
4. ________________________	/ /	____

Parent's names: ____

Address: ____

City: ________________________________ State: _______ Zip: __________________

Home Phone: ____________ Cell: ______________ E-mail Address: ______________________

Parent's Employer: ____

Occupation: _________________________ Work Phone: _________________________

Parent's Employer: ____

Occupation: _________________________ Work Phone: _________________________

Please explain any medical condition that would limit your child's participation in competitive swimming.

____

____

EMERGENCY MEDICAL TREATMENT FORM

We, the parents of the children listed above, give permission for emergency medical treatment for our child for illness or accident if we cannot first be contacted.

Doctor's name: ________________________________ Phone: _____________________________

Dentist's name: ________________________________ Phone: _____________________________

Hospital: _____________________________________ Phone: _____________________________

Insurance Company ____

Emergency contact: ____________________________ Phone: _____________________________

Parent signature: ______________________________ Date: ________________________________