



**LAKE COUNTRY SWIM TEAM INC.
LIABILITY/MEDICAL RELEASE FORM**



SWIMMER'S PRINTED NAME _____
LAST FIRST MIDDLE

IF I AM INJURED WHILE PARTICIPATING IN PROGRAMS AT LAKE COUNTRY SWIM TEAM

- 1) I AND MY FAMILY AGREE TO WAIVE ANY LEGAL CLAIM AGAINST USA SWIMMING (USA SWIMMING), AND THOSE ASSOCIATED WITH USA SWIMMING, WISCONSIN SWIMMING INC. AND LAKE COUNTRY SWIM TEAM INC.;
- 2) I GIVE CONSENT FOR LAKE COUNTRY SWIM TEAM INC. TO PROVIDE MEDICAL/ATHLETIC TRAINING ATTENTIONS, TRANSPORTATION AND EMERGENCY MEDICAL SERVICES AS WARRANTED. IF THE PROGRAM IN WHICH I AM PARTICIPATING INCLUDES PHYSIOLOGICAL AND/OR BIOMECHANICAL EVALUATIONS, I FURTHER CONSENT TO THESE EVALUATIONS WHICH POSE NO UNUSUAL RISKS OR HAZARDS WHEN CUSTOMARY SAFEGUARDS ARE OBSERVED.

IF INJURED WHILE TRAVELING TO OR FROM LAKE COUNTRY SWIM TEAM, INC. BY PUBLIC, PRIVATE OR ANY OTHER MEANS OF CONVEYANCE, I AGREE TO WAIVE ANY LEGAL CLAIMS AGAINST USA SWIMMING, WISCONSIN SWIMMING INC. AND LAKE COUNTRY SWIM TEAM INC. BY SIGNING THIS RELEASE, I SWEAR THAT I AM IN GOOD PHYSICAL CONDITION AND I AM NOT AWARE OF ANY DISEASE OR INJURY THAT WOULD RESULT IN MY BEING INJURED DURING ANY PROGRAM PARTICIPATION.

IF I AM LESS THAN 18 YEARS OF AGE OR A MINOR UNDER THE LAWS OF THE STATE WHERE I LIVE, MY PARENT OR GUARDIAN SHALL SIGN THIS RELEASE WITH ME.

I AGREE THAT I WILL NOT BRING OR POSSESS ALCOHOLIC BEVERAGES, ILLEGAL DRUGS, OR INTERNATIONAL OLYMPIC COMMITTEE-BANNED SUBSTANCES ON THE PREMISES. I FURTHER UNDERSTAND AND AGREE TO ABIDE BY GENERAL RULES OF CONDUCT PRESCRIBED FOR PARTICIPANTS IN THIS FUNCTION AND THAT VIOLATIONS MAY RESULT IN A DENIAL OF MEET PRIVILEGES.

Participant Printed Name _____ Birthdate _____

Participant Signature (if over the age of 18) _____ Date _____

Parent/Guardian Signature _____ Date _____

Street Address: _____

City/State/Zip: _____ Home Phone: (_____) _____

If parents are not available, please call the person designated below in case of emergency:

Name: _____ Relationship: _____

Street Address: _____

City/State/Zip: _____ Emergency Phone: (_____) _____

Additional comments regarding medical history, allergies, penicillin or drug reactions, etc., which may be needed in rendering medical treatment:

Parent/Guardian Insurance Information:

Company Name _____ Policy and/or ID # _____ Group and/or Member # _____

Company Address _____ Company Phone # _____