

2017-2018 Registration/  
Medical Form  
**DUE August 10, 2017**

**Registering for:** (circle one)

**Marlins Dolphins Age-Group Seniors Swim School**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
                    First                      Middle initial                      Last    (as of 12/1/17)

ADDRESS: \_\_\_\_\_  
                    Street                                      town township                                      state                                      zip code

HOME PHONE: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Guardian names and work & cell phone #'s:

Guardian #1 \_\_\_\_\_ Guardian #2 \_\_\_\_\_  
                    Relationship \_\_\_\_\_ Male/Female                                      Relationship \_\_\_\_\_ Male/Female

YMCA Swim Team Registration:      New \_\_\_\_\_      Returning: \_\_\_\_\_  
OR General/Fitness Member:      # \_\_\_\_\_      Basic Member: # \_\_\_\_\_

USS Member Yes \_\_\_ Team \_\_\_\_\_ No \_\_\_ **T-SHIRT SIZE Youth \_\_\_\_\_ Adult \_\_\_\_\_ Check one**  
**Circle one   YS, YM, YL   AS, AM, AL, AXL**

**MEDICAL INFORMATION:**

Doctor: \_\_\_\_\_ Phone # \_\_\_\_\_ Hospital: \_\_\_\_\_

Emergency contact : \_\_\_\_\_  
                                    Name                                      Phone #                                      relationship

Medical Insurance: \_\_\_\_\_ ID # \_\_\_\_\_

Are you allergic to any medications?   No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Do you take any prescribed medications on a permanent or semi-permanent basis?  
No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Do you have asthma or other respiratory disease? No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Do you have any learning disabilities that the coaching staff should be aware of?  
No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Are there any other issues that the coaching staff should be aware of?  
No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Participation in HAC programs requires an annual physical.                      Date of last physical: \_\_\_\_\_

If a medical emergency or illness occurs, I authorize the coaching staff of Hamilton Aquatics to send my child to a physician or hospital, and authorize emergency medical treatment.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT RESPONSIBILITIES**

Should my child be responsible for damage to the facilities/equipment at their practice location I understand that I am responsible for restitution.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_