

# Spring Competitive Stroke Clinic & Training

## May 2<sup>nd</sup>-26<sup>th</sup>, 2011

**Group 1** – 10& Under  
Monday and Wednesday  
May 2-25  
5:00-5:45 p.m.

**Group 2** – 11&Up  
Monday and Wednesday  
May 2-25  
5:45-6:30 p.m.

**Group 3** – 10&under  
Tuesday and Thursday  
May 3-26  
5:00-5:45 p.m.

**Group 4**- 11&Up  
Tuesday and Thursday  
May 3-26  
5:45-6:30 p.m.

Swimmer's Full Name (Last, First, M.I.)	Sex (M/F)	Birth date mm/dd/yy	mark all that apply			
			Group I	Group 2	Group 3	Group 4
1						
2						
3						
4						
5						

- Five Points members: one swimmer \$50
- Additional swimmers: \$40
- Prospective members: one swimmer \$60
- Additional swimmers \$50

Checks payable to: Five Points Washington

Total Enclosed \_\_\_\_\_

### Family Information

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip code: \_\_\_\_\_

Email address: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

### *Emergency Contact Information*

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (home/work &/or cell): (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell): \_\_\_\_\_

### PLEASE READ CAREFULLY AND SIGN:

\_\_\_\_\_ HAS MY PERMISSION TO PARTICIPATE IN THE FIVE POINTS WASHINGTON SWIMMING PROGRAM. IN THE EVENT THAT I CANNOT BE REACHED DURING AN EMERGENCY, I(WE) THE UNDERSIGNED GIVE PERMISSION FOR MY CHILD TO BE TREATED BY A LICENSED PHYSICIAN, AND FOR SAID PHYSICIAN TO ADMINISTER WHATEVER CARE IS NECESSARY, INCLUDING ANESTHESIA FOR THEIR SAFETY AND CARE. THE CHILD'S FAMILY WILL BE RESPONSIBLE FOR ALL OF THE ASSOCIATED MEDICAL EXPENSES. ALSO I(WE) WAIVE AND RELEASE ANY RIGHT AND CLAIMS I (WE) MAY HAVE AGAINST FIVE POINTS WASHINGTON, AND ALL MEMBERS OF FIVE POINTS BOARD FOR ANY AND ALL DAMAGES WHICH MAY BE SUFFERED BY MY CHILD IN CONNECTION WITH HIS/HER ASSOCIATION WITH THE SWIMMING PROGRAM.

I also understand that pictures may be taken for promotional consideration and may be used in future publications and advertisements.

**SIGNATURE OF  
PARENT** \_\_\_\_\_

**DATE** \_\_\_\_\_