

<b>Office Use</b>	
Res Form: _____	1 <sup>st</sup> Month: _____
Prnt Code: _____	Swim Code: _____
Fraising Amount Paid: _____	



## Competitive Swimming Registration 2007-2008

<http://www.swimnyac.org>

*Please be sure to complete the entire registration form*

Family Name: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School District of residence: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ E-Mail Address #2: \_\_\_\_\_

Emergency Contact: (Name and Phone) \_\_\_\_\_

**1st months payment, (or paid in full amount) and team fundraising fee are due at registration.  
 The remaining 4 month payments (November-February) will be by Bank Draft/Credit Card**

Swimmer Last Name	First Name	Middle Initial	Gender	Birth date	Practice Group Requested

**Emergency Medical Release:** Should a medical emergency arise during my child's participation with in a YMCA sponsored activity, I understand that reasonable effort will be made to contact me or the emergency contact I have provided. If I cannot be reached, or if it is believed that my child's life or health may be adversely affected by the delay that an attempt to contact me would cause, I consent to the administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility chosen by the YMCA and I consent to the immediate administration of life sustaining measures deemed necessary under the circumstances.

I have read and understand the above Medical Release section and agree to the terms and conditions therein

Signature \_\_\_\_\_ Date \_\_\_\_\_

*If you wish to withdrawal from the program, this must be done in writing to G. Michael Gobrecht, Director of Competitive Swimming, West Shore YMCA 410 Fallowfield Road, Camp Hill, PA 17011-4900. Refunds will be made through the end of October. **No refunds will be made after November 1, 2007***