



Co-ed Swim Team Registration Form

Swim Team registration begins Apr, 2022. Please provide all the information requested. Mail completed form with payment to: Your local Pool. To register by phone, call Your local Pool (Blue Earth 526-3376 or 526-2715). Use one form for each Person you register. Practice will be Tue & Thur. @ 12:15-1:15. Starting Jun 14th We will have Intramural Meets against AM lap swimmers, Lifeguards, and a Parent meet.

MAIN CONTACT INFORMATION

Parent/guardian's full name: _____ Relationship to Student: _____
Address: _____ Day phone: _____
City/State/ZIP: _____ Evening phone: _____
Email address*: _____ Cell phone: _____
confirmation and information will be sent via email.

Student INFORMATION

full name: _____ Grade in fall 2022: _____
school: _____ Date of birth: _____
Emergency contact name: _____ Primary phone: _____
Relationship to student: _____ Secondary phone: _____

SWIM TEAM REGISTRATION

Start date: June 8, 2021 End date: July 31, 2022 Swim Team Location: Blue Earth Pool.

List any accommodations needed (accessibility, interpreter, allergies, etc.): _____

PERMISSION

I give permission for my Son or daughter to attend and to participate in all phases of this program, including field trips if applicable. I give permission to take photographs and/or video of my son or daughter for publicity purposes. I verify that my Son or Daughter can swim at least 25 yards.

Parent/guardian signature: _____ Date: _____

PAYMENT INFORMATION

- Swim Team Fee: **\$40 For the Blue Earth Swim Team**
 Payment method: Check/money order payable to Blue Earth Pool enclosed: \$ _____

Student Health History Form

Please print clearly in ink. MEMBER ADULT MEMBER Staff

CONTACT INFORMATION	Individual <input type="radio"/>			
	First Name:	Middle Name:	Last Name:	
	Mailing Address:		Apt. #:	PO Box:
	City:	State:	Zip Code:	Phone: ()
	Cell: ()	E-mail:		
	Parent/Guardian(s) Name and address (If different)		Phone: ()	Cell: ()
	Parent/Guardian(s) Name and address (If different) 2.		Phone: ()	Cell: ()
Custodial Care Information: <input type="radio"/> Both Parents <input type="radio"/> One Parent (specify): _____ <input type="radio"/> Other: _____				
HEALTH INFORMATION	Name of Family Physician:		Phone: ()	
	Family Medical/Hospital Insurance Carrier:		Policy or Group No:	
	Family Dental Insurance Carrier:		Policy or Group No:	
	Health Information: Age: _____ Date of Birth: _____ <input type="radio"/> Immunizations are up to date.			
	Date of last Tetanus shot: _____			
	Date of last health examination: _____		Were there any medical problems at the time? _____	
	Does participant have any physical, mental or psychological conditions requiring medication, treatment, or other special restrictions or considerations <input type="radio"/> Yes <input type="radio"/> No If yes, please state medication and reason: _____			
	Does participant take any prescribed medications or over-the-counter drugs on a regular basis? <input type="radio"/> Yes <input type="radio"/> No If yes, please state medication and reason: _____			
	Is participant restricted or limited from participating in any physical activity? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain: _____			
	Please provide a record of past medical treatment, if any, including injuries or surgeries: _____			
Participant has the following health conditions/allergies/dietary restrictions (food and medications): <input type="radio"/> ADHD <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Headaches <input type="radio"/> Seizures <input type="radio"/> Other: _____ <input type="radio"/> Allergies (specify): _____				
Emergency Contact (non-parent):				
Relationship:		Phone: ()	Cell: ()	
AUTHORIZATION	PARENT/GUARDIAN AUTHORIZATION This health form is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my Son/daughter should not participate in the prescribed activities except as noted. In the event that my Son/daughter needs medical attention while participating in Swim team activities I authorize the adult in charge to see that my Son/daughter receives routine healthcare, medications, reasonable first aid, and to transport my child to health care facility for emergency services as needed.			
	Signature of parent/guardian: _____		Date: _____	
	ADULT MEMBER AUTHORIZATION This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.			
Signature of adult member: _____		Date: _____		