

**Official Use Only**

Amount Paid:

Receipt No:

Date:

|  |  |
| --- | --- |
| **Today’s date:** |  |
| **ATHLETE INFORMATION** |
| **Last Name** | **First Name** | **Middle Name** | **Preferred Name** |
|  |  |  |  |
| **Birth Date** | **Age** | **Gender: Male/Female** | **Club Number** |
|  |  |  |  |
| **Swimmer’s Email** | **Cell Phone** |
|  | ( ) |
| **PRIMARY MAILING INFORMATION** |
| **Father/Parent 1****First Name** | **Last Name** | **Mother/Parent 2****First Name** | **Last Name** |
|  |  |  |  |
| **Mailing Address** |
|  |
| **City** | **State** | **Zip Code** |  |
|  |  |  |  |
| **Home Phone** | **Home Fax** |
| ( ) | ( ) |
| **Father/Parent 1****Office Phone** | **Cell Phone** | **Mother/Parent 2****Office Phone** | **Cell Phone** |
| ( ) | ( ) | ( ) | ( ) |
| **Father/Parent 1****Email** | **Mother/Parent 2****Email**  |
|  |  |
| **LEVEL INFORMATION** |
| Returning swimmers, make sure to check the TWST bulletin board or contact the coaching staff for appropriate team level. |
| **Team Level** | **Year** | **Season (Fall/Winter or Spring or Summer)** |
|  |  |  |
| **bgcucaquatics.org/** | **(908) 687-2697 ext 109** |



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| **IF SWIMMER OVER 18** I hereby grant permission, in case of injury, to have an athletic trainer and/or medical doctor provide medical assistance and/or treatment. |
| Name | Signature | Date |
| **IF SWIMMER UNDER 18** If you are under 18 years of age, a parent/guardian must provide consent for you to be given medical assistance and/or treatment by signing immediately below.  |
|  |  |  |  |
| **Name of Parent/Guardian** | **Relationship** | **Signature** | **Date** |
|  |  |  |  |
| **INSURANCE INFORMATION** |
| If Athlete is covered by any insurance company, please complete the following |
| **Name of Carrier** | **Policy Number**  |  |
|  |  |
| **Address** |
|  |  |  |  |
| **MEDICAL HISTORY QUESTIONNAIRE**Please Circle the correct answer: |
| Yes No | Has this athlete ever been hospitalized, had surgery, injury, and/or serious illness? |
| Yes No | Is this athlete now under the care of a physician or taking medication? |
| Yes No | Has any physician ever recommended limits on competitive sports? |
| Yes No | Does this athlete have any allergies to medication? |
| Yes No | Does this athlete wear glasses or contact lenses? |
| Yes No | Has this athlete ever blacked out or lost consciousness during exercise? |
| If the answer is YES to any of the above questions, please specify. |
|  |
| Doctor’s Name | Doctor’s Phone | Emergency Contact | Emergency Contact Phone |
|  | ( )  |  | ( ) |
| Any Medical Condition | Medication |
|  |  |
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