

**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** | |



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 | | |
|  | | |  | | |
| bgcuaquatics.org/ | | | (908) 687-2697 ext 109 | | |