



**Office Use**

Program Fee Paid: \_\_\_\_\_

Admin Amount Paid: \_\_\_\_\_

Escrow Amount Paid: \_\_\_\_\_

# Competitive Swimming Registration Summer 2010

[www.swimnyac.org](http://www.swimnyac.org)

Family Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Employer: \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

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

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

E-Mail Address: \_\_\_\_\_

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

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

Swimmer Last Name	First Name	MI	Gender	Birth date	Y Member Y/N	Practice Group

**Emergency Medical Release:** Should a medical emergency arise during my child's participation at 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 West Shore 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 Scott Zacharda, Head Swimming Coach NYAC, 410 Fallowfield Road, Camp Hill, PA 17011-4900.*

