

FTFRC SWIM TEAM
Registration Form 2010

		Medical Release Form
Parent Name: _____		I/We _____, Parent(s) of _____ give my/our permission for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry in the event that I cannot be reached immediately.
Home Phone: _____		
Work or cell phone: _____		
Address: _____		
Parent Name: _____		
Home Phone: _____		
Work or cell phone: _____		
Address: _____		
Swimmer D.O.B. Age 5/30/10		My child's physician _____
1. _____		Phone # _____
2. _____		My child's dentist _____
3. _____		Phone # _____
4. _____		Known allergies _____
5. _____		Insurance coverage _____
\$40 swim team fee/swimmer _____		Insurance # _____
(Max. of \$120)		A phone number parent can be reached _____ Parents signature _____ Date: _____