

Enrollment Date (office):

Bayshore Clubhouse Swimming Lessons 2010

SESSIONS (check)
 July 12,14,19,21,26,28
 Aug 2,4,9,11,16,18

Name of Child: _____ Birthdate: _____ Age: _____

Mother/Co-Parent/Guardian circle one	Father/Co-Parent/Guardian circle one
Mailing Address	Mailing Address
City/State/Zip	City/State/Zip
Home Phone Cell/beeper	Home Phone Cell/Beeper
Email (very important)	

The undersigned agrees to indemnify, defend, save, and hold harmless the Bayshore Owners Association from any claim, lawsuit, or liability, including attorney fees and costs, allegedly arising out of loss, damage or injury to myself or child in connection with Association activities.

X Signature of Parent or Legal Guardian _____ Date _____

_____ Level 1a	Mon & Wed 4:00pm to 4:30pm	_____	\$48 Bayshore members per session
_____ Level 1b	Mon & Wed 4:30pm to 5:00pm	_____	\$60 Non-members per session
_____ Level 2	Mon & Wed 5:00pm to 5:30pm	_____	Total Paid ___Cash ___Check ___CC

CONSENT FOR MEDICAL OR SURGICAL CARE

This authorizes Bayshore Owners Association to give permission to appropriate medical or hospital personnel to provide emergency medical or surgical care for the child hereinabove listed in the event I cannot be contacted immediately. I understand that every effort will be made to locate me or my child's other parent or legal guardian as soon as possible. I understand my obligation to keep my child care provider informed of my whereabouts. I will assume the cost of necessary medical or surgical care. This authorization will not expire as long as my child is in swim lessons at Bayshore Owners Assoc.

Witness

Signature of Parent or Legal Guardian

Date signed

Date signed

HEALTH HISTORY FOR SWIM LESSONS (confidential info for lifeguards)

Name of Child: _____ Birthdate: _____

The purpose of this health history is so that the swim instructors have the most up-to-date information about your child for safety purposes. Please circle the following regarding your child:

Y N ADD/ADHD comments: _____

Y N Allergies, if so, what (i.e. food, bee stings, latex) _____

If yes, does your child use an inhaler? Y N

Y N Diabetes

If yes, please list symptoms of low blood sugar: _____

Y N Hearing problems. If yes, please explain: _____

Y N Physical limitation. If yes, please explain: _____

Y N Seizures. If yes, type? _____

Healthcare provider? _____ Phone: _____

How often do they occur? _____

What does a typical seizure look like and how long does it last? _____

In the event of a seizure, what would you like us to do? _____

Please explain any other behavioral or medical issues we should know about _____
