

(one form for each child must be completed)

Official use	Swim Group _____
Membership fee _____	
Registration fee _____	Amt. Paid _____ Amt.
Due _____	
Attire fee _____	Cash _____ CK # _____

Last name _____ First name _____ MI ____

Preferred Name _____ DOB _____ Age _____ M / F _____

Address _____

City _____ State _____ zip _____

Parents Name _____

Home # _____

Wk # _____ (M / F) Cell # _____ (M / F)

Emergency # _____ email address _____

Were you a swimmer on another USS Swim team? _____ When? _____

If so, what was the name? _____ Team Abbreviation _____.

I, _____ agree to release Youth Swimming, Inc., Walton Waves, Inc. , Youth Athletic Recreation Company, Inc., & Staff, Bluesprings Sports Ranch & Staff from any responsibility for property damage, illness, or injury incurred by my child at Bluesprings. I agree to allow Walton Waves Swimming Staff, or another authority to administer First Aide for my child, if necessary. I, the undersigned, will be responsible for any & all costs of medical attention and/or treatment.

Website information: Swimmers names and pictures may appear on or through our website - www.waltonwaves.com in the form of meet entries, meet results, rosters, as well as team pictures and action photos.

Signed _____ Date _____

Please

make checks payable to : WALTON WAVES

You can mail registration form to: Walton Waves

1810 Kristins Way
Loganville, Georgia 30052

OR bring by pool M-F, 4-6pm.

If you have any further questions please call **(770) 466-8353**

MEDICAL HISTORY AND RELEASE FORM

Name: _____ **Parents:** _____

Check if your child has had any of the following:

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> cardiac problems | <input type="checkbox"/> asthma | <input type="checkbox"/> chronic ear problems |
| <input type="checkbox"/> seizures | <input type="checkbox"/> diabetes | <input type="checkbox"/> chronic illness |

If any of the above is checked, please provide a statement from the treating physician clearing the child for swim team participation.

Describe any other health problem not listed

above: _____

List all

surgeries: _____

List all medications he/she is

taking: _____

List any ALLERGIES (medications

&insects): _____

Physician Name &

phone#: _____

I, _____ (parent/guardian print name) hereby give permission for any and all medical attention to be administered to my child, _____ (child's name), in the event of accident, injury or sickness, under the direction of the person(s) below, until such time as I may be contacted. I also assume responsibility for the payment of any such treatment.

Youth Swimming, Inc., Walton Waves, Inc., Youth Athletic Recreation Company, Inc., & Staff, Bluesprings Sports Ranch & Staff from will not be held responsible for property damage, illness, or injury incurred by my child at Bluesprings.

Address _____

Home Phone _____ **Work Phone** _____

Emergency Contact:

Name _____

Phone# _____ **Relation** _____

Insurance Plan & Policy Number: _____

In case I cannot be reached, any of the following persons are designated to act on my behalf:

- * Coach * Assistant Coach * Designee of the Walton Waves Swim Team

Parent/Guardian Signature _____ **Date** _____