

2017 CRESTWOOD SWIM & DIVE TEAM REGISTRATION

Fees for child 1 - 3:	Swim Team: \$60	DiveTeam: \$55	Both: \$100
Fees for child 4+ :	Swim Team: \$55	Dive Team: \$50	Both: \$90
(family discount applies to the fees for the fourth and subsequent children)			

Registration will be held at the **Exeter Jr. High School Library** on the following dates:

Saturday, April 29, 2017 from 9:00 - 11:00 am

Monday, May 8, 2017 from 6:00-8:00pm

**D & J will be at both registration dates for
team swimsuit & swim cap sizing and orders**

PLEASE NOTE: if you cannot attend in-person registration, please mail your registration, checks payable to Crestwood PAC by May 17, 2017 to:

Crestwood PAC c/o Melissa Crotty
312 Grande Valley Road
Reading, PA 19606

Any registrations postmarked **May 18** or after will incur a **\$10 late fee.** This applies to returning members only.

****If you are new to the team and not sure if you want to join, you may submit the registration paperwork and fee by the May 17th deadline. A refund will be granted if requested after the first full week of practice. Purchased swimsuits cannot be returned or refunded.****

****Crestwood Pool Membership is required for all Swim and Dive Team memberships. This is stated in the BCSA constitution****

General swim/dive team questions can be directed to:

**PAC@crestwoodpool.com
Crestwood Swim and Dive**

Summer 2017 Member Registration

Family Last Name: _____ (New/Returning/Referred by _____)

Mailing Address: _____

PARENT INFORMATION:

Parent 1:

Last Name: _____

First Name: _____

Cell Phone #: _____

Email: _____

Parent 2:

Last Name: _____

First Name: _____

Cell Phone #: _____

Email: _____

ATHLETE INFORMATION:

Last Name (if different)	First Name	Gender	Date of Birth	Age on 7/28/17	Swim /Dive /Both	Shirt Size YS, YM, YL, YXL, AS, AM, AL, AXL
		M F			S D B	
		M F			S D B	
		M F			S D B	
		M F			S D B	
		M F			S D B	

Please list any health concerns (Conditions, Allergies, Medications) along with your child's name below:

EMERGENCY CONTACT NAME & NUMBER: _____

PHYSICIAN NAME & NUMBER: _____

Signature _____ Date _____