



# DOLPHIN FINSWIMMING CLUB Ltd.

## Registration Form

Surname: \_\_\_\_\_

Given Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Gender: F M  
(mm/dd/yyyy)

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

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_

(cell) \_\_\_\_\_ (other) \_\_\_\_\_

Email: \_\_\_\_\_

Parent/Guardian(s):

1) \_\_\_\_\_ | \_\_\_\_\_  
print signature

2) \_\_\_\_\_ | \_\_\_\_\_  
print signature

Date: \_\_\_\_\_  
(mm/dd/yyyy)

### ***Waiver***

#### **READ CAREFULLY BEFORE SIGNING**

I/We \_\_\_\_\_, the parent(s) or lawful guardian(s) of \_\_\_\_\_ do hereby release DOLPHIN FINSWIMMING CLUB Ltd, The City of Port Coquitlam and its successors or assigns from any and all actions, claims or causes of actions arising out of instructions provided to my/our child or arising out of any finswimming, swimming, running practices, meets or other functions attended or sponsored by the DOLPHIN FINSWIMMING CLUB Ltd.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Parent/Guardian's signature: \_\_\_\_\_ | \_\_\_\_\_  
print signature

Witness: \_\_\_\_\_ | \_\_\_\_\_  
print signature

**Athlete Medical History**

Name: \_\_\_\_\_ Gender: F M

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

BC Care Card Number: \_\_\_\_\_

Parent/Guardian(s): 1) \_\_\_\_\_

2) \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**Alternate Contact (In Case Of Emergency):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

**Record of Illness: (Check the following):**

Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ Blackouts \_\_\_\_\_ Chest pain \_\_\_\_\_

Seizures \_\_\_\_\_ Heart Disease \_\_\_\_\_ Headaches \_\_\_\_\_ Surgery \_\_\_\_\_

Serious illness \_\_\_\_\_ Injuries \_\_\_\_\_ Allergies \_\_\_\_\_ Contact Lenses \_\_\_\_\_

If you checked any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**To Whom It May Concern:**

In the event that I could not be contacted after an emergency involving my child,

\_\_\_\_\_, I hereby authorize the official chaperone or the coach of the DOLPHIN Finswimming Club Ltd. to authorize whatever medical aid is deemed necessary by the attending physician. I will approve these authorizations and do not hold anyone responsible.

Parent/Guardian's signature: \_\_\_\_\_  
print | signature

Witness: \_\_\_\_\_  
print | signature

Date: \_\_\_\_\_  
(mm/dd/yyyy)