2021 CRESTWOOD SWIM & DIVE TEAM REGISTRATION

Fees for child 1 - 3: Swim Team: $60   DiveTeam: $65   Both: $110

Fees for child 4+ :   Swim Team: $55   Dive Team: $60   Both: $100

(family discount applies to the fees for the fourth and subsequent children)

Registration will be held at **CRESTWOOD POOL** on the following dates:

Saturday, May 8 , 2021 from 9:00 - 11:00 am

Monday, May 10 , 2021 from 6:00 - 8:00pm

Team Suits - Sizing kits will be available during registration

and can then be ordered online.

PLEASE NOTE: if you cannot attend in-person registration, please mail your registration, checks payable to <u>*Crestwood PAC*</u> *by May 21, 2021 to:*

Crestwood PAC c/o Sarah Stapley
4 Brookside Ct
Birdsboro, PA 19508

Any registrations postmarked **May 21st** 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 21th 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 2021 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 7/24/21	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 _____