

EDGERTON OTTER SUMMER SWIM TEAM REGISTRATION

Make checks payable to: City of Edgerton

Mail to: Edgerton Pool 12 Albion Street Edgerton, WI 53534



Parent's Name: _____

Address: _____ City: _____

Phone Number: _____ Email: _____

Swim Team members

Participant's Name	Gender	Age	Birth Date	Strokes	Years of Experience

	Timer	Scorekeeper	Ribbon writer	Set-up	Runner
Volunteer Opportunity					

*****Swim team is open to age 6-18, however, you must be able to swim a length of the pool, 25 yds., for 7-9 yr. olds; 2 lengths of the pool, 50 yds for 10-18 yr. olds, Freestyle. **Although failure in the above area does not prevent a child from being on the swim team and attending practice. It is understood the coach's responsibility will be to provide stroke evaluation, improve mechanics, and some correction. The coach cannot, due to time constraints, teach the child how to swim--this is the swimmer and parent's responsibility.***

In exchange for the privilege of using these facilities, I agree that I will be liable to and hold harmless the City of Edgerton and its officers and officials, agents and employees against all loss or expense including attorney fees by reason of any claim and suits, or because of bodily injury including death at any time resulting wherefrom, sustained by any person or person or an account or damage to property, including loss of use thereof, arising from, in connection with, caused by or resulting from my act or omission in attending and using these facilities, whether caused by or contributed to by the City or its agents or employees. I grant permission for my photo to be used in any promotional material produced by the City of Edgerton.

Signature required for participation _____ **Date** _____

FOR OFFICE USE:

CHECK # _____ CASH _____ Total Collected _____ Date _____ INITIALS _____

Emergency Medical Authorization

PART I OR II MUST BE COMPLETED

Participant's Name _____

Address: _____ City: _____

Phone: Home _____ Cell: _____ Work: _____

Purpose: To enable parents and guardians to authorize the provisions of emergency treatment for children whom become ill or injured while under Coaches' authority, when parents or guardians cannot be reached.

Part I – TO GRANT CONSENT

Emergency contact _____ Phone _____

I hereby give my consent for (1) the administration of any treatment deemed or (2) in the event the need to transfer the child _____
to _____ (preferred hospital) or any hospital reasonable and accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed Doctors or Dentists, concurring in necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any other physical impairments to which a physician should be alerted:

Date: _____ Signature or Parent or Guardian: _____

Address: _____ City _____

PART II – REFUSAL TO CONSENT (Do not complete PART II if you completed PART I)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the Park Authorities to take no action or to:

Specific

instructions: _____

Date: _____ Signature of Parent/Guardian: _____