

**NEWINGTON SC, INC.  
REGISTRATION FORM / MEDICAL RELEASE FORM  
SWIM YEAR 2010/2011**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ FEMALE \_\_\_\_\_ MALE \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOME TELEPHONE \_\_\_\_\_ Parent cell phone \_\_\_\_\_

E-MAIL ADDRESS (*Please print clearly*) \_\_\_\_\_

PARENT(S)/GUARDIAN \_\_\_\_\_

ALLERGIES \_\_\_\_\_

CHRONIC ILLNESS/SPECIAL NEEDS \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOSPITAL OF CHOICE \_\_\_\_\_

I \_\_\_\_\_ HEREBY GIVE NEWINGTON SC, INC'S COACH OR REPRESENTATIVE PERMISSION FOR ANY AND ALL MEDICAL ATTENTION NECESSARY TO BE ADMINISTERED TO MY CHILD, NAMED ABOVE IN THE EVENT OF AN ACCIDENT, INJURY, OR SICKNESS UNTIL SUCH TIME AS I MAY BE CONTACTED. THIS RELEASE IS EFFECTIVE UNTIL THE CONCLUSION OF THE **2010-2011** SWIM SEASON. I ALSO HEREBY ASSUME THE RESPONSIBILITY FOR PAYMENT OF ANY SUCH TREATMENT.

I ACKNOWLEDGE THAT MY CHILD, SWIMMING WITH OR FOR THE TEAM, IS WHOLLY VOLUNTARY ON THE PART OF MY CHILD AND MYSELF AND I FURTHER ASSUME THE RESPONSIBILITY FOR PAYMENTS OF ANY MEDICAL AND/OR DENTAL TREATMENT REQUIRED IN THE EVENT OF ACCIDENT, INJURY, OR SICKNESS.

INSURANCE PROVIDER \_\_\_\_\_ POLICY # \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE: \_\_\_\_\_

\*I am willing to share my name and phone number on a team roster to be distributed to the whole team (please circle one):  
YES NO

\*\*Please note a **mandatory team swim suit and cap** will need to be purchased, date and time for the fitting and the cost will be available at tryouts.

\*\*\***Please fill out *completely* and submit with a copy of birth certificate, thank you.**

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CHECK # \_\_\_\_\_ AMT. \_\_\_\_\_ CASH \_\_\_\_\_ TOTAL \_\_\_\_\_

REGISTRATION PMT Y/N    MEDICAL RELEASE Y/N    BIRTH CERT Y/N