# *2022* SUMMER SWIM LEAGUE*

Child **Last** Name: _____**First** Name:_____M.I.___ BIOLOGICAL GENDER (M/F)_____

Child Preferred Name or "Nickname"_____Child Birthdate: (mm/dd/yy)_____

Parent Name (Father)_____ (Mother)_____ School Attended:_____

Street Address:_____City, State, Zip: _____

Primary Cell:(MOM) _____(DAD)_____

**Email**: _____

_____

## Fees:

$195* ***(Includes USAS Flex Registration, PB County Parks & Rec BOCC Training Fees, Lightning Team Shirt & Summer Swim League cap)***

***Checks to: "Lake Lytal Lightning" PayPal: lightningswimming@gmail.com***

***Venmo: "lakelytallady"***

*These non-refundable fees cover your 21 available practices May 31-July 14 (June 7-July 14 HSDev) regardless of lightning cancellations. Remember mornings have less a chance for thunderstorms

Progress is determined by your son/daughter's willingness to participate & practices attended.

**GOOGLES mandatory & CAPS** (if hair gets in eyes or touches shoulders…these impede progress, thus the cap).

I hereby grant permission for my child to participate on the Lake Lytal Lightning Swim Team and agree to indemnify and hold harmless the Lake Lytal Lightning and its officers, agents, employees, and volunteers help, any community organization co-sponsoring the program, Lake Lytal Lightning Parents Booster Club, USA Swimming, Florida Gold Coast swimming & Palm Beach County Parks & Recreation Dept., from and against any and all liabilities for any injury which may be suffered by my child arising out of or in any way connected with his/her participation in the program named above, including, but not limited to losses or liabilities arising out of the acts or omissions of the Lake Lytal Lightning Swim Team or its officers, agents, employees, volunteer help, and community organization co-sponsoring the program, Lake Lytal Lightning Parents Booster Club, USA Swimming, Florida Gold Coast swimming and the Palm Beach County Parks & Recreation.

**Signed**_____**Date**_____

To whom it may concern: As a parent or guardian of the Child named on this form ("Child"), I authorize a qualified and licensed medical doctor to treat the Child in the event of a medical emergency which, in the opinion of the attending physician, may endanger the Child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach the below named. This authorization form is completed and signed on my own free will with the sole purpose of authorizing medical treatment for the the Child under emergency circimstances in my absence.

**Signed**_____ **Date**_____

Specific medical allergies, chronic illness or other conditions:_____

Additional contacts in case of emergency: _____