AKRUG AQUATIC CLUB, INC.
REGISTRATION FORM
MAY TO JUNE
2024 STROKE CLINIC

****Must be able to swim 25 yards****
5:30-6:30 p.m. or 6:30-7:30 p.m. or
6:00 - 7:30 p.m. Senior Team (circle which time slot)

1. **SWIMMER'S NAME:_____**
   AGE:_____DATE OF BIRTH:_____
2. **SWIMMER'S NAME:_____**
   AGE:_____DATE OF BIRTH:_____
3. **SWIMMER'S NAME:_____**
   AGE:_____DATE OF BIRTH:_____

PARENTS NAME:_____

ADDRESS:_____
_____
_____
E-Mail: _____
PHONE(HOME)_____(CELL)_____
(BUSINESS)_____(EMERGENCY)_____
MEDICAL PROBLEMS:_____
(EX. SEIZURES, ASTHMA, HEART DISEASE, DIABETES, ETC.)

I hereby authorize any representative of the Akrug Aquatic Club, Inc. to have the above named minor(s) treated in any medical emergency during their participation in the Akrug Aquatic Club program. In addition, we agree not to hold William Paterson University, Akrug Aquatic Club, Inc., team members or Coaches responsible for any accident or other such occurrences.
SIGNED;_____DATE:_____