AKRUG AQUATIC CLUB, INC.

MARCH TO MAY
2025

Please circle which group:

6:30 p.m. To 7:30 p.m. or Senior Team 6:00-7:30 p.m.

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:____
____
EMAIL: _______________________________________
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:________