C.I.T. Registration

Name_____

Address _____

Age _____ Date of Birth_____ Gender ____

Mother's Name_____ Cell Phone _____

Father's Name_____ Cell Phone _____

Hair Color_____ Eye Color_____ Height_____ Weight____

Swimming Ability _____

Identifying Marks _____

Does your child have any physical restrictions/Allergies?_____

_____

Medications:_____

List any medical, physical or emotional conditions_____

Health Care Provider: Name / telephone:_____

Address _____

RELEASE & IN CASE OF AN EMERGENCY*

If a parent/guardian cannot be reached:

Name_____ Phone_____

Authorization & Consent

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the qualified staff at the Boys & Girls Clubs to transport my child to the nearest hospital.

Parent/Guardian Signature:_____ Date: _____

	6/22-6/26	6/29-7/3	7/6-7/10	7/13-7/17	7/20-7/24	7/27-7/31	8/3-8/7	8/10-8/14
Select up to 2 weeks max.								

C.I.T. Registration

Name_____

Address _____

Age _____ Date of Birth_____ Gender ____

Mother's Name_____ Cell Phone _____

Father's Name_____ Cell Phone _____

Hair Color_____ Eye Color_____ Height_____ Weight____

Swimming Ability _____

Identifying Marks _____

Does your child have any physical restrictions/Allergies?_____

_____

Medications:_____

List any medical, physical or emotional conditions_____

Health Care Provider: Name / telephone:_____

Address _____

RELEASE & IN CASE OF AN EMERGENCY*

If a parent/guardian cannot be reached:

Name_____ Phone_____

Authorization & Consent

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the qualified staff at the Boys & Girls Clubs to transport my child to the nearest hospital.

Parent/Guardian Signature:_____ Date: _____

	6/22-	6/29-	7/6-7/10	7/13-7/17	7/20-7/24	7/27-7/31	8/3-	8/10-8/14
Select up to 2 weeks max.								