

Aquatics Program Registration Form

Program: _____ Date(s) of Program: _____ Time of Program: _____

Participant's Name: _____ Age: _____ Sex: M F

ID#: _____ Home Phone: _____ Cell Phone: _____

Address: _____
Street City State Zip

Email Address: _____

Check one: Student Faculty/Staff Alumni Guest of _____

WHO TO CALL IN CASE OF AN EMERGENCY

Name: _____ Relationship: _____

Address: _____
Street City State Zip

Day Phone: _____ Evening Phone: _____

MEDICAL HISTORY

Please describe any conditions you have that require ongoing medical attention or medication that could affect your performance during the activity (i.e. back injuries, knee problems, pregnancy, etc.).

DO YOU HAVE ANY OTHER MEDICAL PROBLEM, CONDITION, OR PAST MEDICAL HISTORY THAT WE SHOULD BE AWARE OF (i.e. high blood pressure, epilepsy, unusual shortness of breath, diabetes, etc.)?

For Student Fitness Center Reception Desk Only

Amount Paid: \$ _____ Cash Check Credit _____

Signature of Reception Desk Attendant