

CARDINAL AQUATICS 2010 CLINIC REGISTRATION FORM

CLINIC Registration Fee: \$165

HOW DID YOU HEAR ABOUT US? _____

FAMILY INFORMATION (also used for billing and contact information)

Family Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ E-Mail: _____

Primary Contact

Parent/Guardian: _____

Parent/Guardian Work#: (____) _____

Parent/Guardian Cell#: (____) _____

Secondary Contact

Parent/Guardian: _____

Parent/Guardian Work#: (____) _____

Parent/Guardian Cell#: (____) _____

(Signature) Date: _____

SUMMER LEAGUE TEAM: _____

SWIMMER INFORMATION

Swimmer 1

Name: _____ Date of Birth: _____

Last

First

Middle Initial

Preferred Name: _____ Sex: M-F (____) USA Citizen? Yes (____) No (____)

Dual Citizen? Yes (____) No (____)

If your swimmer was previously registered with another USA Swim Team please fill out the line below

Team: _____ LSC: _____ Last Date of Competition: _____