For Office Use Only:
Date: ______________________
Fee Paid: __________________
Staff: _____________________
Receipt #:__________________

City of New Bern Parks & Recreation
"First Dip"
Beginning Swimmers Program

Child's Name:___________________________ Sex: M/F Home Phone:_________________
Mother's Name:____________________ Phone(H)________________ (W)_______________
Father's Name:______________________ Phone(H)________________(W)________________
Child's Address:____
Child's Date of Birth: ____/____/____ Child's Current Age:______ Grade:______
Do you live in the New Bern City Limits? Yes No Do you live in Craven County? Yes No
E-Mail: ________________________________ Cell #'s__________________________________

Registration Fee: $10 per-session City Residents
(City Residents must live within City limits)
Registration Begins Monday April 19, 2010

Circle the session and check the level of the desired lesson

Session 1	Session 2	Session 3	Session 4
Tues-Fri,	Tues-Fri,	Tues-Fri,	Tues-Fri,
Tues@	Tues@	Tues@	Tues@
7:15p-7:45p	7:15p-7:45p	8:30a-9am	8:30am-9am
6/1-6/4	6/8-6/11	6/15-6/18	6/22-6/25

Program is designed to offer a Basic water skills and orientation for child ages 3-10yrs old

Family member will not be allowed on the pool deck or in the water while instruction is be taught until approved times

Goals of Program are to improve children's comfort level in water and enter and exit skills improved.

Children not in the correct level may be moved within the session if room is available without exceeding a 1 to 6 ration of instructor to student, and a maximum of 24 students per session.

STATEMENT OF UNDERSTANDING

Student's Name: ______________________________

This outlines the client/parent liability for deliberate damages and/or vandalism to property that is under the ownership of New Bern Parks and Recreation Department. The statement "property" is defined as building exteriors and interiors as well as, the grounds property within the West New Bern Center, Stanley White Center, and the Community Resource Center.

Any member of the lesson program who willfully damages or defaces property will be held responsible for damages (includes parent or guardian) and considered for suspension or termination from the program.

I understand that when my child's class ends for the day, Aquatic Programs responsibility for him/her ends and it is my responsibility to pick up my child promptly.

Please sign and initial to indicate that you have read and understand this policy.

_____________________________ ____________________

Parent/Guardian Signature Date

Parent/Guardian Initials: ___________ Date: ______________

Student Initials: __________________ Date: ______________

MEDICAL HISTORY

Student Name: ______________________________________ Date of Birth: ________________

Height: ____________________________ Weight :_________________________

Insurance Company Name ______________________________Policy Number: _____________

Parent/Guardian Daytime Telephone Number: ___________________ Cell:________________

Name of Family Physician____________________________ Telephone Number:___________

Yes	No	Have you ever had/been? (please check appropriate column)
		Diabetes
		Epilepsy
		Heart Disease
		Asthma
		High Blood Pressure
		Back Problems
		Dislocations – If yes, to which joint?
		Seizures-If yes, what tends to trigger them?
		Muscle Spasms – If yes, what tends to trigger them?
		Are you highly sensitive to heat?
		Are you highly sensitive to cold?
		Are you currently taking medication? If yes, what? What side effects do they have?
		Are there any limitations to your activities? If yes, what?
		Allergies to medications? If yes, what?
		Allergies to insect bites? If yes, what?
		Allergies to plants? If yes, what?
		Other (Please state any other condition not listed)

I am aware of my child's general condition and affirm that he/she is fit to participate in medium to strenuous physical activity. My child will engage in all prescribed activities except for those noted by my examining physician.

________________________________ ________________________________

Parent/Guardian Signature Date

MEDICAL INFORMATION FORM

Student Name: ______________________________________ Date of Birth: ________________

Height: ____________________________ Weight :_________________________

Insurance Company Name _____________________________Policy Number: _____________

Person carrying insurance: _______________________ Relationship to child:_______________

Parent/Guardian Daytime Telephone Number: ___________________ Cell:_______________

Name of Family Physician____________________________ Telephone Number:___________

List any medical, psychological or emotional conditions your child is being treated for at the present time: ____

List all medications he/she is currently taking:
____

List all allergies and allergic conditions of your child: ___________________________________

____

List any restrictions of physical activity that apply to your child: __________________________

____

List any disabilities or conditions that would prevent your child from participating in this program and any kind of special accommodations your child would need to participate in the B.E.A.R. program. ____
____
____

Medical Treatment Consent and Liability Release:

I, the undersigned parent/guardian, do hereby grant permission for my son/daughter to receive necessary medical treatment in the event of any injury or illness while attending special programs sponsored by B.E.A.R. and I accept responsibility for the full payment of such medical treatment. I hereby hold B.E.A.R. and their representatives harmless in the exercise of this authority.

______________________________ ______________________________
Parent/Guardian Signature Date