



For Office Use Only:
Date: _____
Fee Paid: _____
Staff: _____
Receipt #: _____

# City of New Bern Parks & Recreation

## America Red Cross Swimming Lessons the Aquatics Center

### Summer, 2010

**Registration Fee: \$40 City Residents \$70 Non-Residents**  
 (City Residents must live within City limits)

**Registration Begins Monday April (19), 2010 for City Residents and  
 May 1<sup>st</sup> for  
 Non- Residents**

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 \_\_\_\_\_

**Circle the session and check the level of the desired lesson**

Session 1
Levels 1 & 2
6/15-17 & 6/22-25
Tue-Fri @
9:15a-9:45am

Session 2
Levels 1 & 2
6/29- 7/2 & 7/6- 9
Tue-Fri @
9:15a-9:45am

Session 3
Levels 1 & 2
7/13-16 & 7/20-23
Tue-Fri @
9:15a-9:45am

Session 4
Levels 1 & 2
7/27- 30 & 8/3-6
Tue-Fri @
9:15a-9:45am

**Please complete the exit skills assessment sheet (white copy) before selecting swim level**

If you are not sure about the level, you may bring child in to be evaluated during a public swim time by one of the supervisors or a head lifeguard. You will need to be in the water during the evaluation if the child is less than 4 feet tall and cannot float. If you stay in the pool after the evaluation, you will need to pay the public swim fee.

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.

Family Members will not be allowed on the pool deck or in the pool during lessons; there will be an opportunity to view students provided during lesson.

**If there is not room to move the child within the session, they will be removed from lessons and you will receive a credit that can be used in another session.**

**Swimming lessons are offered for the following Groups (check one)**

\_\_\_\_ Level 1: Water Exploration (3yrs and older; no previous lessons)  
 \_\_\_\_ Level 2:

## 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