ARROWHEAD
COUNTRY CLUB

ARROWHEAD SUMMER SWIM TEAM 2017

PRE SEASON FORM (MAY 1st - May 26th)

HEAD COACH : CHRIS AIKMAN 602-570-2284

EMAIL : SWIMAIKMAN11@MSN.COM

THIS IS THE TIME TO FINE TUNE YOUR STROKES AND BE READY FOR THE FIRST SWIM MEET!

8 & UNDER | TUES & THURS 4 PM - 5 PM
9 & OVER | MON - WED - FRI 4 PM - 5 PM

MEMBER PRICING
_____ $80 FOR ALL 4 WEEKS
_____ $$25 PER WEEK

NON MEMBER PRICING
_____ $100 FOR ALL 4 WEEKS
_____ $35 PER WEEK

Parent Information

Name:_____ Phone: _____

Email:_____

Swimmer Information

Name: _____ DOB:___/___/___ Age: _____ Cost: _____

Name: _____ DOB:___/___/___ Age: _____ Cost: _____

Name: _____ DOB:___/___/___ Age: _____ Cost: _____

Name: _____ DOB:___/___/___ Age: _____ Cost: _____

Name: _____ DOB:___/___/___ Age: _____ Cost: _____

THERE ARE NO REFUNDS FOR PRE - SEASON

Payment options on the Back

Total: _____

PAYMENT OPTIONS

1) CHARGE TO COUNTRY CLUB MEMBERSHIP ACCOUNT #_____

2) PAYMENT BY CHECK: MADE OUT TO ARROWHEAD COUNTRY CLUB

CHECK NUMBER _____ DRIVERS LICENSE # _____

3) PAYMENT BY CREDIT CARD

TYPE OF CARD:_____ CARD # _____

CARD HOLDERS NAME:_____CARD EXPIRATION DATE:_____

AMOUNT CHARGED: $_____

4) PAYMENT BY CASH: CASH TOTAL $_____

I AGREE TO THE CHARGES AND ACCEPT ALL REFUND POLICIES AS STATED ABOVE

_____

Medical Information

Doctors Name:_____ Doctor's Phone:_____

Primary Medical Insurance: _____

Policy Number: _____

If your child has any medical conditions we should be aware of please list and explain:

_____

_____

_____

In the event of a medical emergency and if unable to contact the designated physician or me, I hereby authorize the Arrowhead Swim Team Coach in attendance to: provide medical assistance, treatment, and/or transportation to the nearby medical facility for my child.

Signature of Parent or Guardian _____ Date_____