ARROWHEAD
COUNTRY CLUB

ARROWHEAD SUMMER SWIM TEAM 2017

SEASON FORM (MAY 30th- JULY 13th)

HEAD COACH : CHRIS AIKMAN 602-570-2284

EMAIL : SWIMAIKMAN11@MSN.COM

AGES 13 & OVER | MON - FRI 9:00 - 10:00 AM
AGES 9 - 1 2 | MON - FRI 10:00 - 11:00 AM
AGES 8 & UNDER | MON - FRI 11:00 AM- 12:00 PM

_____ $150 MEMBER PRICING
_____ $175 NON - MEMBER PRICING

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: _____

NO REFUNDS AFTER JUNE 8th & ONLY 50%
REFUND PRIOR TO JUNE 8th

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_____