



Blue Fins Swim Team
 P.O. Box 270926
 San Diego, CA 92198
 e-mail: bfstcoach@hotmail.com
 www.rbbluefins.org

FOR OFFICE USE ONLY:
 Group: _____
 Dues Paid: _____
 USS _____
 Check # _____
 Start Date: _____
 Rec'd by: _____

Swimmer's Name(s):

 Last First MI Birthdate

 Last First MI Birthdate

 Last First MI Birthdate

 Parent's Names: Occupation (Optional)

 Address City State Zip

 Home Phone Work Phone Cell Phone

Vons Club Card # (eScrip Fundraiser): _____

 Name - E-mail (for billing) Name - E-mail

 Name - E-mail Name - E-mail

Have you participated with Blue Fins previously? ____ Year Round ____ Summer League ____ SwimAmerica

How did you hear about us? _____

I can help with: ____ Meets ____ Phone Calls ____ Activities ____ Group Parent ____ Other

PARENT CONSENT AND MEDICAL AUTHORIZATION

I (We) give our consent and authorize _____ to participate in all activities conducted by Blue Fins Swim Team and Streamline Aquatics, Inc. If a Parent, Family Physician or Dentist cannot be contacted, and a medical or dental emergency exists, I (We) authorize any Blue Fins Swim Team Coach or Representative of the Team to obtain emergency medical or dental care for him/her by any licensed physician/dentist.

 Family Physician Phone Family Dentist Phone

Please list any medical conditions of which the TEAM should be aware:

 Father's Signature Date Mother's Signature Date