

## MOM/DAD AND ME

(6 mo.-3 yrs)

### PURPOSE:

Promote water safety knowledge and practice water adjustments, as well as have fun and enjoyment in the water.

Develop a trusting relationship between parents and children and the instructor. A parent or guardian must accompany every child in the water.

COST: \$33.00/SESSION (6 Sessions)

### CONTACT PERSON:

Fay Matsumoto 776-2228

Email: [fay\\_matsumoto@yc.edu](mailto:fay_matsumoto@yc.edu)

Mail registration to:

Fay Matsumoto, HPER

Yavapai College

1100 E. Sheldon St. Prescott, AZ 86301

### SESSIONS:

SATURDAYS

Oct 10- Nov 14

### TIME:

9:00-9:30AM



FILL OUT BOTH FORMS BELOW AND SUBMIT WITH YOUR PAYMENT. PLEASE PRINT  
REGISTRATION FORM

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Fee Enclosed \_\_\_\_\_ \$33

OCT 10-NOV 14, 2009

*Make check payable to: Yavapai College*

Mail Check and Registration/Medical Release forms to:

**Yavapai College HPER, 1100 E. Sheldon St. Prescott, AZ 86301**

## MEDICAL RELEASE FORM

PLEASE COMPLETE FROM IN ITS ENTIRETY AND SIGN.

Participant's General Health \_\_\_\_\_ Insurance \_\_\_\_\_

Company \_\_\_\_\_

Current Medications \_\_\_\_\_ Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Drug Sensitivities \_\_\_\_\_ Name of Policy \_\_\_\_\_

Holder \_\_\_\_\_

Allergies \_\_\_\_\_ Policy \_\_\_\_\_

Number \_\_\_\_\_

Preferred Local Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

# \_\_\_\_\_

I hereby agree that I will not hold Yavapai College, the Board of Directors/Trustees and or Yavapai Swim School, its instructors and employees responsible for any loss, damages or personal injury incurred as a result of participation. I hereby authorize the Instructors and Assistants to act for my child according to their best judgment in an emergency requiring medical attention. I agree to allow my child to be treated by a licensed physician (if necessary) and I will assume all cost(s) related to such treatment. I authorize my insurance company to pay benefits to the Yavapai Regional Medical Center. Also I authorize the disclosure of medical information to my insurance company for the purpose of claim. I give my child permission to participate in Yavapai Swim School. \_\_\_\_\_ (Parent/Guardian Initial)

Parent or Guardian

Signature \_\_\_\_\_ Date \_\_\_\_\_