



Aquatic Registration Form Summer 2023

Billing Information

Last Name _____ First Name _____ Member Non-Member

Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____

Swim Lessons

Private Semi-Private (must provide group)

Name: _____ DOB: _____ Number of Lessons: _____ Fee: _____

Preferred Days of Lessons: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Please note that schedule will be determined with the aquatics staff once registration is received.

Notes: _____

J-Rays Swim Club (Family Membership Required)

Name: _____ DOB: _____ Grade (School Yr. 2023-24): _____ Fee: \$350

Payment

Payment: Cash Check CC # _____ Exp Dat: _____

Cardholder's Signature: _____ Total Amount Enclosed: _____

Emergency Authorization

Please Note: I hereby appoint the appropriate JCC staff members to act on my behalf in authorizing unexpected medical, dental or surgical care/or hospitalization for the below names minor(s) during the period of May 26, 2023, through September 4, 2023, in the event of my unavailability

Name	Date of Birth	Allergies/ Special Conditions

Medical/ dental /hospitalization coverage for the above minor(s):

Insurance company/ government program: _____ ID/ group # : _____

Physician: _____ Phone Number: _____

Publicity Release

I hereby give do not give permissions for my above names child(ren) to be used in the JCC of Syracuse promotional pieces.

Agreement/ Release Signature

I recognize that participating in athletic/recreation programs have certain inherent risks which the Jewish Community Center of Syracuse is not liable. I hereby, for myself, executors and administrators, waive and release any and all claims for damages I may seek against the JCC, or places used by the JCC in conjunction with this athletic/recreation program. I also recognize that medical expenses I may incur in connection with the participation in this athletic/recreation program are my own responsibility. I hereby appoint the appropriate JCC staff to act on my behalf in authorizing unexpected medical, dental, surgical or hospital care should I be unable to do so. I have read the preceding paragraph as acknowledgment by my signature below.

Signature _____ Date _____