

Dana Point Aquatic Center AKA Aloha Swimming

Registration, Medical/Liability Release Form

Date of Session _____ Requested Time Frame _____ M T W TH F S

Swim Level _____ Medical needs _____ (More space for details on the back of this form)

Lesson Type (circle one)

Swim Lesson JR Guard Prep Lap Water Exercise Parent/Tot Swim Workouts Preschool Play

Name of Participant _____ DOB _____

Name of Participant _____ DOB _____

Parent Name _____ Phone _____ Cell _____

Address _____ City _____ Zip Code _____

Emergency Contact Name _____ Phone _____

EMAIL ADDRESS REQUIRED _____ (Most communication is sent through email)

We/I the enrolled participant and/or Patron, Parent or Legal Guardian of above participant/s, willing agree to comply with all the customary terms and conditions for participation. However, if We/I observe anything unusual or a significant hazard during my presence or participation, I will immediately bring it to the attention of the staff on hand and may choose to remove myself from participation. We /I give permission to participate in Dana Point Aquatics Center Inc. (DPAC) AKA Aloha Swimming activities which are supervised by professional staff and volunteers for instruction or pool use without a lifeguard for personal use. We/I know that DPAC is a private non-commercial facility. We/I understand that the sport of swimming and related activities has inherent risks. The risk of injury from any activity at DPAC can be significant, including the potential for PERMANENT PARALYSIS, DEATH and DISABILITY. No matter how minor or significant the accident, We/I agree that We/I will forever waive our right to any and all claims, demands, action or cause of action by participant and to hold harmless and agree to indemnify DPAC aka Aloha Swimming, officers, facility, the facility owner, facility staff or volunteers that may be the result of participation in any and all activity at the facility, EVEN IF ARISING FROM NEGLIGENCE OF THE RELEASES OR OTHERS. And, In the event of injury/illness, we give our consent to any x-ray, exam, anesthetic, medical treatment or hospital care which is deemed advisable by the general or specific supervision of any Lifeguard, EMT or Physician, Surgeon, or Dentist licensed under the provisions of the Medical Practice Act. It is understood that every effort will be made to contact or ask permission of the undersigned prior to treatment. But treatment will not be withheld should the undersigned not be reached or able to respond. Furthermore, We/I agree to pay all costs associated with medical care and transportation of the patron or participant.

WE/I HAVE CAREFULLY READ THE ABOVE LIABILITY RELEASE AND SIGNED IT WITH FULL KNOWLEDGE OF ITS CONTENTS AND SIGNIFICANCE.

I agree and sign _____ Dated _____