

**Children's Swim Program  
Application, Medical Information, Liability Release &  
Parental Consent Form**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**Please check:**

- Parent-Tot**
- Pre-School Swim Class**
- Private or Semi-Private Swim Lessons**
- Level 1: Tuesday & Thursday 4:00 pm:**  
**Start Date:** \_\_\_\_\_
- Level 2: Monday & Wednesday 4:00 pm:**  
**Start Date:** \_\_\_\_\_
- Summer Mornings: Start Date: \_\_\_\_\_ Time: \_\_\_\_\_ Level: \_\_\_\_\_**
- I am interested in Readiness Evaluation**

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

Has child participated in swim lessons? Yes  No

Is child comfortable in the water? Yes  No

Does child have any water experience? Yes  No

Can child float? On front  on back

Has child previously worn swimmyies or life jacket for comfort in the water? Yes  No

Comments: \_\_\_\_\_

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**Release of Liability/Parental Consent Form**

***Please read and sign if participant is a minor or under the care of Person Authorized to Consent***

I, \_\_\_\_\_, (print name of parent or guardian), hereby release, waive, discharge and covenant not to sue Wake Forest University Baptist Medical Center, North Carolina Baptist Hospitals, Inc. and Wake Forest University School of Medicine, their affiliates, agents, therapists, and other employees of the organization, other participants, sponsoring agencies, their heirs, successors and assigns, and if applicable, owners, and lessors and lessees of premises; all of which are hereinafter referred to as "releasees" from demands, losses or damages on account of injury, including death, or damage to property caused or alleged to be caused in whole or in part by the negligence of the releasee or otherwise.

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided in favor of the Releasees, and, for myself, my heirs, assigns, and next of kin. I release and agree for myself and my minor child to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in this program as provided above.

\_\_\_\_\_  
Signature of Parent or Person Authorized to Consent for Participate

\_\_\_\_\_  
Date

Please note any medical conditions or concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician Information**

Physician's Name: \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_

Please complete the application form and return via fax or mail to:

**Aquatic Program**

PO Box 571207

Winston-Salem, NC 27157-1207

**Or Fax To:**

Debbie Drayton

Fax: 336-713-8193