

# Ahwatukee Community Swim and Tennis Center Registration Form

- For additional registration forms, photocopy this original or call the Community Swim & Tennis Center at 480-893-3431.
- Complete this form, one per child. Cash, check, visa or master card payments are accepted in person. Hours of operation are: 7:30 am - 9:30 pm Monday through Thursday and 7:30 am - 7:00 pm Friday, and 7:30 am - 11:30 am on Saturday and Sunday. We are located at 4700 E. Warner Rd., just west of 48<sup>th</sup> Street behind Blockbuster.
- Cancellations may be made one week prior to first day of camp. There is a cancellation fee of \$50 if cancellation is made less than one week prior to camp.

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## 1. Camper Information (one form per child)

Camper's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Camper's Address: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Father/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Mother/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Preferred E-mail Address: \_\_\_\_\_

## 2. Emergency Contacts (other than parent/guardian)

Name: \_\_\_\_\_ Phone(s): \_\_\_\_\_  
Name: \_\_\_\_\_ Phone(s): \_\_\_\_\_

## 3. Persons authorized to pickup camper

Name: \_\_\_\_\_  
Name: \_\_\_\_\_  
Name: \_\_\_\_\_

## 4. Medical Information

Allergies: \_\_\_\_\_  
Medical Problems: \_\_\_\_\_  
Medication: \_\_\_\_\_

## 5. Select Camps Desired

\_\_\_\_\_ March 13 - 16    \_\_\_\_\_ June 5 - 8    \_\_\_\_\_ June 19 - 22  
\_\_\_\_\_ July 10 - 13    \_\_\_\_\_ July 24 - 27    \_\_\_\_\_ July 31 - Aug 3    \_\_\_\_\_ Oct. 9 - 12

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### Emergency Medical Release - Must sign in order to participate

I, the undersigned parent of the above referenced participant, hereby acknowledge and understand that in the event that any emergency medical situation arises relative to any of the above referenced participants, the Ahwatukee Community Swim and Tennis Center will contact public officials through 911 calls but will not be responsible for directing the care of the child or hospital and doctor to whom the child will be sent.

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

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### FOR OFFICE USE ONLY

Payment: ( ) Cash: Amount \_\_\_\_\_ ( ) Check: Check No. \_\_\_\_\_ Amount \_\_\_\_\_  
( ) MasterCard/Visa: Amount \_\_\_\_\_

