



# 2024 FALL SWIM Clinic

## SIGN UP FORM

### SEPT 3rd – OCT 24th

### MONDAY - THURSDAY



**5/6** YEAR OLDS 3:30PM TO 4:00PM



**7/8** YEAR OLDS 3:45 PM TO 4:30 PM



**9 & UP** YRS OLD 4:30 PM TO 5:30 PM

**HVCA Port Streets Residents \$195 - Non-HVCA Port Streets Residents \$220 per swimmer**

There is no pro-rating of fees for partial attendance due to absences, injury or inclement weather  
**CASH or CHECK** made out to **HVCA** Please drop off your payment at the pool office Phase 1  
at 1854 PORT WESTBOURNE PLACE, NEWPORT BEACH, CA 92660

**PARENT(S) NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

**CELL #:** \_\_\_\_\_

**EMERGENCYCONTACT:** \_\_\_\_\_ # \_\_\_\_\_

PARTICIPANT(S) NAME	AGE	DATE OF BIRTH	SWIM EXPERIENCE

### FEES MUST BE PAID AND WAIVER SIGNED PRIOR TO PARTICIPATION.

*Enrollment is very limited so please confirm enrollment by dropping registration at **Phase 1 Pool** Emergency Medical Authorization: (Agent: Authorized agent of Harbor View Community Association) I/We, parent(s)/person(s) having legal custody/ legal guardianship of the above listed minor do hereby authorize medical, dental or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office or said physician, dentist or at said hospital. It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required but is given to provide authority to the aforesaid Agent to give specific consent to any; and all such diagnosis, treatment, or hospital care which a physician or dentist meeting the requirements of this authorization may in the exercise of his/her best judgment deem advisable.*

**List allergies if any** \_\_\_\_\_

**Release of Liability:** In consideration of your accepting this registration, I hereby agree to indemnify and hold harmless the Harbor View Swim Team, and any of its officers, agents, or employees from any liability or claim or action for damages resulting from or in any way arising out of participation in the program by the person.

Form of payment: Cash/Check \_\_\_\_\_ Check No. \_\_\_\_\_ Parent Signature \_\_\_\_\_ Date \_\_\_\_\_