

Spring²⁰²⁶ Swim Jr. Guards

Start training by organizing regular swim sessions with your friends to improve endurance and stroke techniques to ensure you're well-prepared for **HVST** and **JR. LIFEGUARDS test!**

MARCH 2 - APRIL 9th

MONDAYS thru THURSDAYS

3:30 pm to 4:00pm 5/6 & 7 year olds (swim only)

4:00 pm to 4:45pm 7/8/9 year olds (Swim & Jr. Guard Training)

4:45pm to 5:45pm Ages 9 & up swimmers (Swim & Jr. Guard Training)

The Cost is \$200 **Port Streets Resident** — \$250 **Non-Port Street Resident**.

CASH, ZELLE to harborviewaquatics@gmail.com or CHECK payable to **HARBOR VIEW AQUATICS**

FEES MUST BE PAID AND WAIVER SIGNED PRIOR TO PARTICIPATION.

You can email the sign up form with Zelle confirmation

PARENT(S) NAME: _____

Print Clear EMAIL: _____

PARENT CELL #: _____

EMERGENCY CONTACT: _____ PHONE: _____

SWIMMER NAME	AGE	Allergies?	SWIM TIME SESSION

FEES MUST BE PAID AND WAIVER SIGNED PRIOR TO PARTICIPATION

NO REFUND POLICY FOR REGISTRATIONS: There is **NO Pro-Rating** of fees for partial attendance due to absences, injury or inclement weather. Once paid, registration fees for any swim programs and other events are non-refundable. Please drop off your payment at the pool office Phase 1 - 1854 Port Westbourne Place, Newport Beach, CA

Release of Liability: In consideration of your accepting this registration, I hereby agree to indemnify and hold harmless the Harbor View Swim Team, coaches and HOA. 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.

_____ Parent Signature

_____ Form of Payment & Date