MASTERS PROGRAM ENROLLMENT FORM

Thank you for your interest in joining the Atlantic Diving Team Masters adult diving program. Your safety, ongoing participation, and enjoyment are important to the coaching staff and to US Masters Diving. To enroll, please complete the following information and return it to the coaching Staff.

CONTACT INFORMATION

Divers Name: ____

(Last) (First) (Mr./Mrs./Ms.)

Address: ________________________________ City: _________________ State: _______ Zip: ___________

Contact Phone: ________________________________ Mobile: _________________________________

E-mail: ____

USA Diving Membership ID: _________________ - OR - AAU Membership ID: ________________

Valid Until: ___________ Valid Until: ___________

PERSONAL INFORMATION

What is your history, if any, with Diving?

How did you hear about the program?

What are your primary interests in the program? (Fitness, Personal Challenge, other?)

What would you like to learn, accomplish or gain?

Would you like to compete? (Y/N/Maybe) Have you competed in the past?

www.AtlanticDivingTeam.com - www.teamusa.org/USA-Diving - www.diveaau.org - Mastersdiving.org

Do you have any history with diving or similar sports? (If no, that's OK!)

Are you currently a member of US Diving or AAU Sports? (Y/N)

Tell us more about yourself:

Do you have children enrolled at Atlantic Diving Team? (Y/N)
If YES, who?

How many days / week are you interested in diving? Which days?

Are you interested in morning or evening workouts?

Do you have any injuries currently or in the past that might be a factor? (Y/N)
If yes, describe:

Do you have travel or other factors that may require flexibility in your schedule?

Do we grant permission to share photos, videos, or provided quotes of or involving you in publications or promotional materials? (Y / N)

PAYMENT INFORMATION & AUTHORIZATION

Payment authorization is available via a check mailed or handed to coaching staff the first day of dive at the beginning of each month, via Electronic Fund Transfers or via credit card payment by Paypal (subject to additional processing fees). Please select your preferred method of payment:

______ Invoice - Check will be provided monthly, payable to **Atlantic Diving Team** with "Child's Name" in the memo

______ Invoice via Bank Transfer (ACH) payment, subject to $1.00 processing fee

______ Invoice via Online secure credit card payment, subject to 3.5% + 0.30 processing fee.

______ Online payment with Paypal, subject to 3.5% + 0.15 processing fee.

Authorization: The above information is true to the best of my knowledge

____ Date: ___________________________
(Diver signature)

Participant Waiver & Emergency Medical Form

Diver's Name____ Birth date____________________________

Program Level_______________________________________ Date________________________________

Street Address____ Phone # (H)__________________________

City, State, Zip____ Phone #(W)_________________________

E-mail ____ Phone #(cell)__________________________

Emergency Contact Name __________________________________ Phone: (_______) __________ - __________

The Atlantic Diving Team offers some classes and programs on a limited basis. There are certain risks inherent in the use of equipment and/or participation in certain programs that you should consider before you begin such activities.

As a participant in these classes and programs, the undersigned on behalf of our minor dependents and ourselves (collectively, "our") understand that participation can involve physical activity, which could result in injury. The undersigned also understands that use of the facilities is exclusively limited to the area(s) in which the class or program is being conducted and that use will be strictly under staff supervision.

For, and in consideration of, the Atlantic Diving Team these programs, and the City of Pompano Beach allowing use of its facilities for this program, and with the understanding of the risks involved in our participation, the undersigned on behalf of ourselves, our dependents and heirs agree to release and forever discharge the Atlantic Diving Team and the City of Pompano Beach, their officers, directors, employees, contractors and agents from any and all liabilities, demands or claims for loss or damage resulting from an injury or damage which may be sustained on account of our participation in these classes or programs, or use of the facilities.

Emergency Medical Form

I do hereby authorize and consent to Atlantic Diving Team ("Authorized Party"), obtaining for the Participant any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital or emergency room care facility ("Medical Facility") care to be rendered to the participant under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Florida Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or Medical Facility care being required and, except as expressly limited below, is given to provide authority and power to render care which a Physician and Surgeon or Dentist in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned by telephone at the numbers listed below prior to rendering treatment to the participant, but that any of the above treatment will not be withheld if the undersigned cannot be reached. If the Authorized Party is a corporation this authorization shall include any officer, director or employee of said corporation or its affiliates. It is further understood that I (we) the undersigned are responsible for all charges for the abovementioned diagnosis, treatment or hospital care.

This authorization is given pursuant to Section 743.0645, Florida Statutes.

Limitations (if any):____

THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL: ____

MEDICAL INFORMATION: Last Tetanus Toxoid Booster______________________

Physician OR Christian Practitioner:_____________________________________ Phone:(____)____________________

Known Allergies to drugs or foods: ____

Insurance Co: ____ Policy Number: _____________________________

Primary Carrier: ____ Phone: (_______) __________ - __________

Print: ______________________________ Signature: ______________________________ Date: _____________

CITY OF POMPANO BEACH

PARKS, RECREATION AND CULTURAL ARTS DEPARTMENT YOUTH PROGRAMS & ACTIVITIES REGISTRATION FORM

ACTIVITY Atlantic Diving Team

Participant's Name: ________________________________ Age: __________

Street Address: ____

City & Zip: ____

Phone Number: _________________________ Date of Birth: ____________

Parent(s) Name(s): ____

Parent(s) Email Address: ____

Emergency Contact Person/Number: _________________________________

Registration Date: ____

PLEASE READ AND SIGN THE REVERSE

Waiver & Refund Agreement

<u>**NOTICE TO THE MINOR CHILD'S NATURAL GUARDIAN**</u>

PLEASE READ THIS FORM COMPLETELY AND CAREFULLY. You are agreeing to let your minor child engage in a potentially dangerous activity. You are agreeing that, even if the CITY OF POMPANO BEACH uses reasonable care in providing this activity, there is a chance YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY because there are certain dangers inherent in the activity which cannot be avoided or eliminated. By signing this form YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM THE CITY OF POMPANO BEACH IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE that results from the risks that are a natural part of the activity. You have the right to refuse to sign this form, and the City of Pompano Beach has the right to refuse to let your child participate if you do not sign this form.

The undersigned expressly ACKNOWLEDGES, UNDERSTANDS AND AGREES that the activities offered by the City of Pompano Beach Parks and Recreation Department involves the risk of injury and/or death and/or property damage. Accordingly, the undersigned ACKNOWLEDGES that the City of Pompano Beach and/or its OFFICERS, COMMISSIONERS, EMPLOYEES OR AGENTS, all for the purposes herein referred to As "RELEASEE" are not responsible for any bodily injury, death or property damage sustained while participating in the City of Pompano Beach Parks and Recreation Department's activities. The undersigned HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE, RELEASEE from any and all liability to the above named PARTICIPANT/CHILD, his or her personal representatives, assigns, heirs, and next of kin for any and all injury, death, loss, or damage, and any claims or demands therefore whether caused by negligence of RELEASEE or otherwise while the above named PARTICIPANT/CHILD is participating in the activity or activities.

In the event that the above named PARTICIPANT/ CHILD sustains physical injury while participating in the above referenced activity or activities, I hereby authorize and request that said PARTICIPANT/CHILD receive emergency treatment from the City of Pompano Beach Parks and Recreation Department's attending physician or from the individual or individuals licensed by the State of Florida as a medical Service Unit as well as any hospital in the State of Florida.

The UNDERSIGNED further expressly agrees that the foregoing AGREEMENT, WAIVER AND RELEASE is intended to be as broad and inclusive as is permitted by the laws of the state and county and that if any portion thereof is held invalid, it is agreed that the balance shall notwithstanding continue in full legal force and effect.

The UNDERSIGNED HAS READ AND VOLUNTARILY signs this AGREEMENT, WAIVER AND RELEASE and further agrees that no oral representations, statement or inducements apart from the foregoing written agreement have been made.

<u>REFUND POLICY</u>: Full refunds will only be made for programs/classes cancelled by the Parks and Recreation Department. If you request a refund for any other reason, a $15 refund service fee will be deducted from the Program/Class fee paid. All refund requests must be made in writing.
(Registration and application fees are non-refundable.)
"Participants are not registered for a program/activity of the City of Pompano Beach until all necessary paperwork and full payment are submitted. The City of Pompano Beach does not accept partial payments".

____________________________________ ______________________

Parent / Guardian Signature Date