

Ride the WAVE into the 2010 season!

Tidalwaves Winter Swim Clinic 2009-2010

Clinic will emphasize technique and conditioning.

When: November 2nd - February 3rd

Who:	Group #1	Novice 1, 1+, 1/2	3:45 - 4:15	\$225.
	Group #2	Novice 2, 2/3, 3	4:15 - 5:00	\$250.
	Group #3	Novice 4 & Above	5:00 - 6:00	\$275.

Practices are Monday thru Thursday unless specified otherwise

NO PRACTICE: Thanksgiving Day; Dec 21-Jan 3; Jan 18

Where: Marin Academy, Mission & Cottage Streets, San Rafael

Make checks payable to: City of Larkspur

Send this completed form and check to: Marie McSweeney
c/o TAM Masters
P.O. Box 150516
San Rafael, CA 94915

Release & payment must be received before participation.

Preference given to Tidalwave swimmers.

NO REFUNDS will be given - Space is very limited

For Questions, Call Marie McSweeney @ 415-453-9563

Please advise of any medical concerns we should know about.

<p>Registration Group (Circle one) 1 2 3</p> <p>Swimmer Name: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>Email: _____</p> <p style="text-align: center;">Emergency Names & Phone #s</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 70%;">Name/Relationship</td> <td style="width: 30%;">Phone</td> </tr> <tr> <td>1) _____</td> <td>_____</td> </tr> <tr> <td>2) _____</td> <td>_____</td> </tr> <tr> <td>3) _____</td> <td>_____</td> </tr> </table>	Name/Relationship	Phone	1) _____	_____	2) _____	_____	3) _____	_____	<p>Waiver & Release/Consent for Medical Treatment</p> <p>I, the parent/guardian of the swimmer (registrant), a Minor, recognize the possibility of physical injury associated with swimming and swimming pools. I hereby release, discharge and/or otherwise agree to indemnify the City of Larkspur, Marie McSweeney, Marin Academy, affiliated organizations, their employees, and associated personnel, including the Owners of the pool and facilities utilized for the registrant's participation in this program.</p> <p>As the Parent or legal Guardian of the swimmer (registrant), I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of my dependent.</p> <p>Signed _____ Parent or Guardian</p> <p style="text-align: right;">Date _____</p>
Name/Relationship	Phone								
1) _____	_____								
2) _____	_____								
3) _____	_____								

