

2009 MARS MASTERS

Membership Application

Pool:	
TCC	_____
Trinity	_____
HSRC	_____

Swimmer Information:

Legal First Name	Legal Middle Name	Legal Last Name
------------------	-------------------	-----------------

Preferred Name	Birth Date (mm/dd/yy)	Current Age
----------------	-----------------------	-------------

Female Male

Address	City	ZIP
---------	------	-----

Home Phone	Work Phone	E-mail Address
------------	------------	----------------

Cell Phone	Other Alternate Numbers
------------	-------------------------

=====

By signing this membership application I acknowledge that I have received and understand the policies and procedures of the MARS program and I agree to abide by same. The most current registration document supersedes any previous document. I also understand the financial responsibilities associated with joining the MARS program. I understand that some activities of MARS may be the subject of liability insurance protection but that some activities may not be protected by liability insurance. Therefore, in consideration of the benefits to me from the participation in the activities of MARS, and other good and valuable consideration, the undersigned hereby releases MARS, and its directors, officers, agents, coaches, and employees, from any and all claims whatsoever made by any person or entity against MARS arising out of my participation in functions of MARS including, but not limited to, travel to and from MARS functions. The undersigned further agrees to indemnify, defend and forever hold MARS harmless from any and all claims (including any cost of defending claims) whatsoever made by any person or entity arising out of my participation in functions of MARS.

Signature	Date
------------------	-------------



Mid-Cities/Arlington Swimming
Texas, U.S.A., Planet Earth
P. O. Box 13849
Arlington, Texas 76094

Consent for Medical Treatment

Legal First Name

Legal Last Name

Legal Middle Name

Preferred Name

Birth date (mm/dd/yy)

Current Age

Female

Male

Medical Doctor's Name

Medical Doctor's Phone Number

Dentist's Name

Dentist's Phone Number

In case of an emergency please contact:

Name

Phone

Please list any ongoing medical conditions and medications for any condition that you feel is necessary for the coaching staff to be aware of: _____

Please list any medications that you are allergic to: _____

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 my life, limb or well-being.

Signature

Date