CROSSPOINTE SWIM & RACQUET, INC.
CHILDREN'S SWIM CONTRACT
2024

INSTRUCTIONS: (1) Fill out and sign this form, (2) Ask the pool manager to administer the swim test and sign the form in the Pool Attendant Test section, and (3) Take the form to the Community Center during regular business hours. The community manager will then change your child's age category in CellBadge to "Child 10-12 with Swim Test."

CHILD'S NAME_____

CHILD'S COMMITMENT:

I agree to abide by all the Crosspointe Swim & Racquet, Inc. rules, a copy of which was made available to me today.

CHILD'S SIGNATURE _____

PARENT'S RELEASE:

Parents or guardian agree to release Crosspointe Swim & Racquet, Inc. of any liability to accident or injury incurred by their children during their use of the pool facilities as described in the Crosspointe Swim & Racquet, Inc. Rules and Procedures.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE** _____

_____ _____

PARENT NAME (PLEASE PRINT) **ADDRESS**

POOL ATTENDANT'S TEST

I have tested the above-named child in the Crosspointe Swimming Pool and find that he/she can swim one length of the pool (25 meters) without stopping, float on their back for one continuous minute, and tread water continuously for one minute.

POOL ATTENDANT'S SIGNATURE _____ **DATE** _____

EMERGENCY PHONE NUMBERS:

Father: **Home**_____ **Office**_____

Mother: **Home**_____ **Office**_____

Physician_____ **Phone**_____

Insurance Co./Policy No._____

AUTHORIZATION TO TREAT A MINOR:

I (WE) the undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered 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 Virginia Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care which the aforementioned physician, in the exercise of his best judgment, may deem advisable. The above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: _____

_____

Signature of Parent(s)/Guardian_____ **Date**_____