



SYC Youth Sailing Program Application 2010

Priority status will be given to returning SYC members and 2009 students & their siblings. (SYC Membership Application must accompany this form.) Priority status applications will be accepted after March 15, 2010 (must be postmarked March 15 or later). All other applications will be accepted after April 1, 2010 (must be postmarked April 1, 2010 or later). Priority status applications received after April 1, 2010 will be merged with the general applications. **Applications will be accepted by mail only when received at the address below.**

Student Information- Please print clearly

Name (Student) _____ Male Female DOB _____

Street _____ Town _____ State _____ Zip _____

How did you hear about the Sailing Program? _____

Swimming Ability Must be able to swim 25 yards & tread water for 2 minutes

Excellent Average (comfortable in water) Fair (comfortable in water) Poor (not comfortable in water)

Family Information

Parent or Guardian _____

Address _____

Home phone _____

Town _____ State _____ Zip _____

Cell _____ Work _____

Relationship _____

Email _____

<u>Enrollment</u>	Session 1⁺ 6/25-7/9*	Session 2 7/12-7/23*	Session 3 7/26-8/6*	Session 4 8/9-8/20*	<u>Fees</u>	
					Member	Non-member (Circle one)
Beginners 9:00 - Noon	Session Filled	Session Filled	Session Filled	Session Filled	\$310	\$340
Intermediates 1:00 - 4:00 No class on Wednesdays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$280	\$310
Advanced/420 ** 1:30 - 4:30 No class on Wednesdays.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No Session	\$280	\$310

** Must be at least 12 years old, a proficient sailor & have taken at least 2 Intermediate classes or equivalent elsewhere. Applicants need approval from Program Director.

* If school is in session on June 25, then class will start on Saturday, June 26. No class on Monday, July 5.
* Family Day (Optional) - sailing and lunch on the last Saturday of each session.
All sailors are invited to participate in Junior Racing- Wednesdays 1:00 - 4:00

Total Enclosed \$ _____

Make check payable to: Sherborn Yacht Club, Inc.

Liability Release

Appreciating that there is a risk of accident and injury inherent in any water sport, including sailing, I hereby release the Sherborn Yacht Club, Inc. its directors, officers, agents, servants and participants from all liability of any sort and intend that they be held harmless and indemnified for any accident or injury sustained by my child while participating in your program. I understand that payment is not refundable.

Parent or Guardian _____

Date _____

Occasionally photos are taken at the SYC docks for publication in a newspaper or on our web site.

I **do not** want my child's photo published.

Mail application to: **SYC c/o Deb Barnet • 226 Webster Street • Needham, MA 02494**

**Sherborn Yacht Club
Medical & Information Form**

Name _____

Street _____ Town _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____

Physical Handicaps (i.e. wears glasses or contacts, hearing, etc.)

Emotional Issues (i.e. anxieties, fears, hyperactivity, etc.)

Learning Disorders, which may interfere with your child's learning experience
(i.e. ADD, ADHD, other learning problems. Please be specific)

Chronic Ailments

_____ Asthma or other respiratory problems _____ Circulatory or heart problems
_____ Diabetes or hypoglycemia _____ Epilepsy
_____ Hemophilia or other bleeding problems _____ Other _____

Allergies

_____ Insect bites _____ Bee stings
_____ Foods _____
_____ Medications _____
_____ Other, if significant _____

Medications we should know about: _____

Swimming Ability

_____ Excellent _____ Average
_____ Poor/comfortable in water _____ Poor/not comfortable in water

Anything else we need to know so that your child's experience is a good one:

In case of emergency please notify:

1. _____
Name Relationship Phone
2. _____
Name Relationship Phone
3. _____
Name Relationship Phone

Health Insurance

_____ Company Policy Number

_____ Primary Care Physician Tel #

I do/do not wish the physician to be contacted if treatment is required.

Parent/Guardian Emergency Treatment Authorization

I, _____ (Parent or Guardian), authorize the program organizers or their employees to seek emergency treatment if none of the above names can be contacted at the time of an emergency.

Signature _____

Date _____