

## **2010 “Try And Dive” Registration**

We are again offering a one-week try and dive opportunity for families who would like to give diving a go but are not sure the sport is for them. This one-week trial, from May 31 – June 6, would allow prospective divers to participate in team practice sessions and spirit activities before making a full commitment to the team for the 2010 season.

Please return the completed form along with a check payable to **Flower Valley Dive Team** to either one of the 2010 Dive Team Reps:

Ann Horwich, 15205 Hannans Way, Rockville, 20853, 301-929-3125; [annhorwich@yahoo.com](mailto:annhorwich@yahoo.com)

Marian Moriarty, 15005 Rocking Spring Drive, Rockville, 20853; 301-871-3147;

[moriarty3147@verizon.net](mailto:moriarty3147@verizon.net)

**Family Name:** \_\_\_\_\_ **Home Phone #** \_\_\_\_\_  
**Father’s Name:** \_\_\_\_\_ **Work Phone #** \_\_\_\_\_  
**Mother’s Name:** \_\_\_\_\_ **Work Phone #** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**E-Mail Address:** \_\_\_\_\_

Diver’s Name	Boy/Girl	Date of Birth	Age as of 6/01/10	Diver Fee
1				<b>\$10</b>
2				<b>\$10</b>
3				<b>\$10</b>
<b>TOTAL</b>				

A dive team member must be able to swim the width of the pool without touching pool bottom.

<b>Emergency Contact/ Name 1</b>	<b>Phone #:</b>
<b>Address:</b>	<b>Relationship:</b>
<b>Emergency Contact/ Name 2</b>	<b>Phone#</b>
<b>Address:</b>	<b>Phone#</b>
<b>Child’s Physician :</b>	<b>Phone #</b>

**Liability Waiver:** As the parent (or Guardian) of the above mentioned minor(s), I grant permission for this minor to participate in any and all official activities of the Flower Valley Dive Team for the 2010 Summer Season. I assume all risks and hazards incidental to such participation, including transportation to and from such activities; and hereby release and waive any and all claims against the organizers, sponsors, supervisors, other participants and persons

transporting this minor(s). In case of emergency, I give permission for my child to receive emergency medical treatment at the nearest hospital.

X

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**