



www.crewroccs.com

### 2007-2008 Masters Registration Sheet

Name \_\_\_\_\_ Date: \_\_\_\_\_

\*Email \_\_\_\_\_ DOB \_\_\_\_\_

\*Note all communication will be done by email.

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Prior Rowing Experience:

Sweep \_\_\_\_\_ # of years \_\_\_\_\_

Sculling \_\_\_\_\_ # of years \_\_\_\_\_

Person listed below is to be contacted in case of emergency.

Name \_\_\_\_\_ Work phone \_\_\_\_\_ Home phone \_\_\_\_\_

Cell \_\_\_\_\_ Residence \_\_\_\_\_

#### Schedule of fees:

\$25 One time application fee, which includes two free rows. (All necessary forms completed and turned in before rower can participate)

\$150/ qtr payable by 1<sup>st</sup> of each month (January, April, July, October) –Late after the 10<sup>th</sup> (Those joining mid qtr will pay \$50/mo until next qtr listed above-Sorry no monthly prorating)

\*Fees include use of ROCCS, Inc. equipment, insurance coverage and weekly coaching fees only. All regatta, travel or other event fees are at the expense of the individual rowers.\*

Payable and mailed to: ROCCS, Inc.

P.O. Box 50

Lecanto, FL 34460

Practices (rows) are to be held each Saturday from 7-9am on Big Lake Henderson at Wallace Brook Park, Inverness.

I have received and read the ROCCS handbook and agree to adhere to all policies listed that apply to the Maters program or ROCCS as an entity.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Questions, email the coach: Ward Cooper- [mrcooper2u@yahoo.com](mailto:mrcooper2u@yahoo.com)

Or go to: [www.crewroccs.com](http://www.crewroccs.com) and click on the Master's button on top for info and forms





### CONSENT FOR TREATMENT

(Please print.)

I, \_\_\_\_\_ give permission to ROCCS, Inc., to act on my behalf in the event of an emergency. I hereby grant permission for staff of ROCCS, Inc. or the club advisor to take full responsibility and take whatever action is necessary regarding my health or safety in the event I cannot respond or in a situation where time is of the essence. I fully release ROCCS, Inc., and its staff from any liability in connection with these decisions. I grant permission for emergency treatment by a rescue squad, emergency medical technician, private physician and /or hospital or emergency health facility staff, if needed. Any such actions will be taken in the best interests of myself and will be reported as soon as possible.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Rower's Date of birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Employer: \_\_\_\_\_

Spouse's contact information:

Spouse's name: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency contact information:

Name: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

Address: \_\_\_\_\_

Please indicate with a check if you have:

Seizures  Diabetes

History of surgery (specify) \_\_\_\_\_

Asthma (specify degree of infirmity, triggers) \_\_\_\_\_

Physical limitations (specify) \_\_\_\_\_

Severe allergies (specify) \_\_\_\_\_

Special dietary needs (specify) \_\_\_\_\_

Other allergies (specify) \_\_\_\_\_

Other special conditions (specify) \_\_\_\_\_

Date of last Tetanus (specify) \_\_\_\_\_

Does you take any medications? Yes No If yes, specify \_\_\_\_\_

If medications are necessary, written instructions from the rower's physician must be on file. Instructions must include: name of rower for whom medication is prescribed, diagnosis, the name of the medication, dosage, when to administer, and when NOT to administer it, if relevant. Medication must be in the original, labeled container.

I hereby grant permission for ROCCS, Inc. to administer medications to myself as prescribed by my physician. My signature gives permission for both emergency treatment/necessary medical action and medication administration.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

STATE OF FLORIDA - COUNTY OF \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_ day of \_\_\_\_, 20\_\_, by (name of person acknowledging).

(NOTARY SEAL) (Signature of Notary Public-State of Florida)  
(Name of Notary Typed, Printed, or Stamped)

Personally Known \_\_\_\_\_ OR Produced Identification \_\_\_\_\_  
Type of Identification Produced \_\_\_\_\_