



CAROLINA DIVING ACADEMY
Huntersville Family Fitness & Aquatics

2011-2012 Carolina Diving Academy Charge Authorization

Huntersville Family Fitness & Aquatics requires the following information and your authorization to charge your credit/debit card for the months your child(ren) are participating.

HFFA Member: Y/N

Tuition

Tuition payments will be deducted on the 15th of each month.

- Beginning Lessons 1-Day MEMBER [\$70/mos]
- Beginning Lessons MEMBER [\$125/mos]
- Advanced Lessons MEMBER [\$125/mos]

- Beginning Lessons 1-Day NON-MEM [\$85/mos]
- Beginning Lessons NON-MEM [\$150/mos]
- Advanced Lessons NON-MEM [\$150/mos]

Child's Name: _____

Name as it appears on card: _____

Credit Card Type: Visa Mastercard Exp. Date _____

Credit Card #: _____

By signing below, I hereby authorize HFFA to charge the above credit card for my child(ren) to participate in Carolina Diving Academy. I understand this information is confidential and will be kept as part of my records. I will notify Huntersville Family Fitness & Aquatics if I change financial institutions/credit card numbers so that my tuition is not delayed.

Parent Signature: _____

Date: _____



Don't miss out on all that Huntersville Family Fitness & Aquatics has to offer!

We know your diving experience will be wonderful and we invite you to continue that by joining Huntersville Family Fitness & Aquatics to make use of our entire facility. We are pleased to offer a discounted membership rate to all currently enrolled dive academy members and their families.

Rates indicated are based on your level of enrollment with Carolina Dive Academy. These are due monthly in addition to your dive lesson fees and will upgrade you to a Huntersville Family Fitness & Aquatics family membership.

Beginning/Advanced - \$65/month
 High School - \$55/month

Developmental - \$55/month
 Elite - \$25/month

Name of Bill Payer: _____ Date: _____

By signing below, I hereby authorize HFFA to charge my credit card on file for my upgraded family membership . I understand this information is confidential and will be kept as part of my records. I will notify Huntersville Family Fitness & Aquatics if I change financial institutions/credit card numbers so that my tuition is not delayed.

Member Signature: _____

Date: _____

Medical Release Form

Parent/Legal Guardian's Name: _____

Address: _____

Phone #s: Home (____) _____ - _____

Work (____) _____ - _____

Cell (____) _____ - _____

Other (____) _____ - _____

Children's Names	List all Known Medical Conditions, Including Food Allergies and/or Drug Allergies. In Addition, Include Any and All Over-the-Counter and/or Prescription Drugs Taken Regularly.

In an emergency, please contact: _____

Relationship to child/children: _____

Phone #s: (____) _____ - _____ (____) _____ - _____

(____) _____ - _____ (____) _____ - _____

Or contact: _____

Relationship to child/children: _____

Phone #s: (____) _____ - _____ (____) _____ - _____

(____) _____ - _____ (____) _____ - _____

Physician's Name: _____

Address: _____

Phone #s: (____) _____ - _____ (____) _____ - _____

Dentist's Name: _____

Address: _____

Phone #s: (____) _____ - _____ (____) _____ - _____

Primary Insurance Company: _____

Phone #s: (____) _____ - _____ (____) _____ - _____

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to child/children: _____

ID #: _____ Group/Policy #: _____

Secondary Insurance Company: _____

Phone #s: (____) _____ - _____ (____) _____ - _____

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to child/children: _____

ID #: _____ Group/Policy #: _____

Statement of Consent: *(To be signed in the presence of a legalized notary public.)*

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical and or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and or surgery, under the recommendation of qualified medical personnel.

Signature: _____ Date: _____

Notarization:

On this _____ day of _____, _____, _____
(date) (month) (year) (name of parent)

personally appeared before me in _____ County (in the state of _____)

and, in my presence, signed this medical release form.

Name of Notary Official: _____

Signature: _____

Commission Expires: _____

