

# SIERRA NEVADA SWIMMING

## HEALTH AND EMERGENCY INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Initial

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Please indicate action desired in the event of an emergency:

\_\_\_\_ In the event of an accident or other emergency, when a parent is unavailable, I hereby authorize a representative of Sierra Nevada Swimming to make such arrangements as he/she considers necessary for my child to receive medical or hospital care including necessary transportation. Under such circumstances, I further authorize the physician below to undertake such care and treatment for my child as he/she considers necessary. In the event said physician is not available at the time, I authorize such care and treatment to be performed by any licensed physician or surgeon.

\_\_\_\_ In the absence of a parent, call neighbor/friend/relative:

Name/Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

\_\_\_\_ I do not choose the above statement and desire the following action: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Insurance Carrier

Policy Number/Kaiser Number

The undersigned hereby agrees to bear all costs incurred as a result of the foregoing desired action.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

### MEDICAL HISTORY

\_\_\_\_ Please check if there are no known health problems.

\*\*\*\*Please check if there is a history of any of the following and explain:

\_\_\_ Frequent Colds      \_\_\_ Frequent Sore Throat      \_\_\_ Sinusitis      \_\_\_ Convulsions

\_\_\_ Bronchitis      \_\_\_ Abscessed Ears      \_\_\_ Asthma      \_\_\_ Hyperactivity

\_\_\_ Stomach Upsets      \_\_\_ Fainting Spells      \_\_\_ Diabetes      \_\_\_ Epilepsy

Penicillin or other drug reactions: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Other Known Diseases: \_\_\_\_\_

Allergies: \_\_\_\_\_

Additional comments/information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*\*\*PLEASE NOTE: IF YOUR SWIMMER HAS A HISTORY OF ANY MEDICAL PROBLEM WE WILL NEED A LETTER FROM HIS OR HER PHYSICIAN DETAILING THE EXACT MEDICAL ALIMENT, ANY MEDICATION THAT HE/SHE MAY NEED; AND ANY SPECIAL CARE THAT HE/SHE MAY NEED PRIOR TO LEAVING FOR THE ZONE TRIP ON AUGUST 4, 2008.**

**\*\*\* PLEASE ATTACH A PHOTOCOPY OF THE INSURANCE CARD.**