

Valley Area Swim Team Health History Form 2007/2008

Swimmer's name _____ Social Security # _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____ Phone# _____

PARTICIPANTS HEALTH HISTORY – All information provided will remain confidential.

Sex: Male Female

Are you now, or have you ever been treated for any of the following:
(Please check all that apply)

- Asthma
- Back Pain/Injury
- Cancer/Leukemia
- Diabetes
- Dizziness/Fainting
- Epilepsy/Seizures
- Heart Murmur/ Heart Valve Disorder
- Hemophilia
- High Blood Pressure
- Kidney Disease
- Liver Disease
- Lung/Pulmonary Disease
- Mental/Nervous Disorder
- Muscle/Joint Injury
- Rapid Heart Rate/Arrhythmia
- Severe Headaches

Please explain any of the above that have been checked:

Please list any medications the participant is currently taking on a regular basis:

Please list any allergies or reactions to any medications:

Please list any serious illnesses, surgeries or hospitalizations:

Please list any other conditions, diseases, or limitations that may affect or limit full participation in swimming activities:

Are all immunizations current? Yes No

Name of personal physician _____ Phone # _____

Personal health/accident insurance carrier _____

Policy # _____

All the information supplied on this health history form is true to the best of my knowledge. I understand that I should notify the Valley Area Swim Team coaching staff of any change in the swimmers medical status.

Signature of Parent/Guardian

Date