## *PENN TRAFFORD AQUA CLUB*
## *MEDICAL HISTORY*

Swimmer's Last Name:________________________________ First Name:_____________________ M.I. ___

Address:___________________________________________ City:____________________ ZIP _________

Father's Name:___________________________ Mother's First Name:_________________________

Home Phone #:_________________________ Cell Phone #: _____________________________

***Please list any unusual conditions – such as convulsions, asthma, diabetes, heart ailments, rheumatic fever, nose bleeds, etc. List any current medical conditions and medications you are taking at this time.***

_______________________________________________________________________________________

_______________________________________________________________________________________

***Please list any known allergies to medications, food, etc. and type of reaction:***

_______________________________________________________________________________________

Pediatrician Name:___________________________________ Phone #:______________________________

Health Insurance Co.:_________________________________ Phone #:______________________________

Health Insurance Address:______________________________________________________________

Agreement #:________________________________________ Policy #:______________________________

Name of guarantor for insurance:_____________________________________

EMERGENCY CONTACT NAME & PHONE #:____________________________________________________

## Medical History and Permission for Treatment:

I, ______________________________ grant permission to the PTAC Coaching Staff to act as spokesperson in granting permission for emergency treatment or hospitalization, including anesthesia, for my child, _________________________________.

NOTE: Every effort will be made to contact the parent/guardian or nearest relative (as indicated) *before* any treatment is given. Only if that person *cannot* be contacted will the permission be given to a physician to treat an injury or sickness.

The PTAC Coaches are NOT permitted to give over-the-counter medications without written permission. If your child has frequent headaches, allergies, upset stomachs, sore throats, etc., and takes over-the-counter medications, we need to be aware of this. If your child must receive such medications, please indicate those medications that the PTAC Coaching Staff are permitted to administer with written permission, i.e., Tylenol, Advil, Benadryl, Aspirin, etc.

________________________________________ ______________________________

Name of medication(s) Signature of Parent/Guardian

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