INFORMATION FORM FOR ADAPTED COMPETITIVE SWIMMERS

NAME: _____

ADDRESS: _____

AGE: ____ BIRTH DATE: _____/_____/_____ PHONE: (_____) _____ - _____

EVENTS TO BE SWUM: _____ / _____ / _____ / _____ / _____ / _____ / _____

TYPE OF DISABILITY: Blind _____ Mentally Challenged _____ Deaf _____ Physical _____

Other _____

EXTENT OF DISABILITY: Be specific (e.g., totally or partially blind, totally or partially deaf, loss of one or more limbs, multiple disabilities, etc.)

_____

_____

_____

The following person(s) will accompany the swimmer for any needed assistance:

_____

Seizures? Yes _____ No _____ Are you on medications? Yes _____ No _____

NAME OF MEDICATION & AMOUNT: _____

PARENTS OR GUARDIAN'S NAME: _____

PHONE: (_____) _____ - _____

PARENT'S OR GUARDIAN'S SIGNATURE: _____

ATHLETE'S SIGNATURE: _____

PHYSICIAN'S NAME (Please print) _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE #: (_____) _____ - _____

I have examined the above Entrant and, in my opinion, there is no mental or physical reason why he or she should not participate in USA Swimming competition.

_____ _____

Physician's Signature Date