Swimmer Medical History/Permission to Treat

Athlete's Name: _____
Athlete's Age at Zones: _____ Gender: _____
Primary Adult/Parent Name: _____
Primary Mailing Address: _____
_____
Primary Email Address: _____
Home Phone Number: _____
Parent Cell Phone Number: _____

ALLERGIES AND SENSITIVITIES-- Is there a history of skin or other untoward reaction or sickness following injection or oral administration of:

Penicillin	yes	no
Morphine, Codeine, Demerol, or other narcotics	yes	no
Novocain or other anesthetics	yes	no
Aspirin, emperin or other pain remedies	yes	no
Sulfa drugs	yes	no
Tetanus, antitoxin or other serums	yes	no
Adhesive tape	yes	no
Iodine or methiolate	yes	no

Any other drugs or medications? Describe_____
Any food such as egg, milk, chocolate? Describe_____
Allergy to insect bites, bee stings, other? Describe _____

Has swimmer ever received treatment for asthma? yes no
Other physical conditions we should be aware of?

_____
_____
_____

May the following be given to my child for the immediate relief of pain/illness?

Pepto Bismol or similar	yes	no	Dosage_____
Advil or Motrin	yes	no	Dosage_____
Tylenol	yes	no	Dosage_____
Tums or similar	yes	no	Dosage_____
Benadryl	yes	no	Dosage_____

_____
Printed Name of Parent/Guardian

_____
Signature Date

Swimmer Medical History/Permission to Treat

EMERGENCY INFORMATION

Swimmer's Name:_____

In case of an emergency, whom shall we contact:

Name:_____Relationship:_____

Emergency Contact Phone Numbers: Mark best number with *

Home: _____
Cell: _____
Work: _____

Physician: _____ phone number: _____

Dentist: _____ phone number: _____

Medical Insurance: _____Policy Number: _____

Patient ID #_____

Insurance phone number:
(This phone number is necessary to obtain authorization for emergency treatment, usually an 800 number.)

Printed Name of Parent/Guardian

Signature Date

PLEASE ATTACH A COPY OF SWIMMER'S MEDICAL COVERAGE CARD FRONT AND BACK