Chenango Valley Swim Club

Medical history form

Swimmer's name_____ Date _____

Please circle yes or no and provide details where requested.

Has the swimmer ever been treated for:

Epileptic seizure	Yes	No
Diabetes	Yes	No
High blood pressure	Yes	No
Asthma	Yes	No

List asthma medications_____

Heart conditions	Yes	No
Allergies	Yes	No

List medications _____

List food/insects _____

Is there any other medical condition that safety personnel should be aware of?

If yes: _____

Are there medications that safety personnel should know about?

If yes: _____

These questions have been answered completely and truthfully, to the best of my knowledge.

Signature of parent / guardian _____ Date _____