



Yuma Heat Swim Team Medical History

Swimmer's Name _____ (one form per child)

Please circle the appropriate responses below. All information will remain confidential.

Date of last physical exam _____

Date of last tetanus shot _____

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|--|-----|----|
| Has this athlete ever had surgery, a serious injury or been hospitalized? | YES | NO |
| Is this athlete now under the care of a physician or taking any prescription medication? | YES | NO |
| Has any physician ever recommended or do you feel that there should be limits placed upon participation in competitive sports? | YES | NO |
| Does this athlete have any known allergies to medications? | YES | NO |
| Does this athlete wear glasses or contact lenses? Give date of last eye exam below if "YES" | YES | NO |
| Has this athlete ever blacked out or lost consciousness during any physical activity? | YES | NO |

If yes to any of the above, please explain below.

I / We hereby grant permission, in case of injury, to have any coach member of USA Swimming and/or medical doctor provide our athlete with medical assistance and/or treatment.

Parent/Guardian Signature

Date