

Howard County Aquatics ~ Medical History Questionnaire

Swimmer's Name (Last, First, MI): _____

Date of Birth: ___/___/___ Gender: _____ Telephone: (____) _____

Address: _____

City/State/Zip code: _____

Parent/Guardian Name: _____

Family Physician: _____ Telephone: (____) _____

Emergency Contact Name: _____ Telephone: (____) _____

Please check the appropriate answer. (All information will be kept confidential.)

Yes No

() () Has this athlete ever been hospitalized, or had surgery, a major injury or serious medical illness?

() () Is this athlete currently under the care of a Physician for a medical problem or is he/she currently taking medication?

() () Has any physician ever recommended or do you feel that there should be limits placed on participation in competitive sports?

() () Does this athlete have any known allergies to medications? If yes, please specify.

() () Has this athlete ever blacked out or lost consciousness during physical activity?

If you answered YES to any of the above questions, please give additional information here.

Yes No

() () This athlete is in good physical condition and has no condition which would impair participation or endanger their health in a physical swim training program.

Emergency Medical Authorization

Swimmer's Name (Last, First, MI): _____

I/We consent to the participation of the above named athlete in the Howard County Aquatics swimming program. I certify that, to the best of my knowledge, the above named athlete is in good physical condition and has no condition which would impair participation or endanger their health in a physical training program. We will not hold Howard County Aquatics or any of its directors, officers, coaches, or sponsors responsible for any injury during participation in this program.

_____ Signature of the Parent/Guardian (If athlete under 18)

_____ Date

_____ Signature of the Athlete (If athlete 18 or older)

_____ Date

In case of injury, I hereby give the Howard County Aquatics swim team and its coaching staff permission to act on my behalf in seeking medical treatment from any licensed physician, hospital or clinic for my child in the event that such treatment is deemed necessary. I give permission to those administering medical treatment to do so using methods deemed necessary.

_____ Signature of the Parent/Guardian (If athlete under 18)

_____ Date

_____ Signature of Athlete (If athlete is over 18)

_____ Date

If the said athlete is covered by an insurance company, please complete the following:

Name of carrier: _____ Policy Number: _____

Address: _____

Telephone (____) _____