COLES CROSSING CROCODILES SWIM TEAM
MEDICAL FORM

Swimmer's name: _____
(Last) (First) (MI)
Date of Birth:_____Sex:_____ Age:_____

Swimmer's name: _____
(Last) (First) (MI)
Date of Birth:_____Sex:_____ Age:_____

Swimmer's name: _____
(Last) (First) (MI)
Date of Birth:_____Sex:_____ Age:_____

Address:_____ Email:_____

Home Phone:_____ Father's Cell/Work:_____ Mother's Cell/Work:_____

Family Physician's name:_____ Phone:_____

Emergency Contact (other than parent):_____ Phone:_____

MEDICAL HISTORY

(All information will remain confidential)

Taking Medication?_____ Allergies to Medication?_____ Asthma?_____

_____ _____ _____

Under Physician's care?_____ Recently Hospitalized?_____ Serious injuries?_____

_____ _____ _____

Do you have special needs?_____

_____

Have you ever blacked out or lost consciousness during physical activity? _____ If yes, please explain:_____

_____

MEDICAL AUTHORIZATION

I grant permission for my child/children's coach, assistant coach, or responsible adult to obtain medical care for my child in my absence.

_____ _____
Signature of Parent/Legal Guardian Date

RELEASE FORM

I certify that the above information is correct and consent to the participation of the above named swimmer(s) in the Coles Crossing swim program. I waive, release, absolve, indemnify and agree to hold harmless the Coles Crossing Crocodiles swim program and its coaches, directors, and supervisors for any claim arising out of injury to my child.

_____ _____
Signature of Parent/Legal Guardian Date