SAINT JOHN FUNDY TIDE SWIM TEAM

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MEDICAL INFORMATION SHEET

Name: _____

Date of birth: Day _____ Month _____ Year _____

Address: _____

Postal Code: _____

Telephone: (____) _____ Cell: (____) _____

Provincial Health Number: _____

Parent/Guardian #1: Name _____

Business Phone Number:(____) _____

Parent/Guardian #2: Name _____

Business Phone Number:(____) _____

Alternate emergency contact (if parents are not available)

Name: _____

Relationship to Swimmer: _____

Telephone: (____) _____ Cell: (____) _____

Doctor's Name: _____

Telephone: (_____) _____

Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes ❑ No ❑ Medication

Yes ❑ No ❑ Allergies

Yes ❑ No ❑ Previous history of concussions

Yes ❑ No ❑ Fainting or seizure during or after physical activity

Yes ❑ No ❑ Near fainting or Brownouts

Yes ❑ No ❑ Seizures and/or epilepsy

Yes ❑ No ❑ Wears glasses

Yes ❑ No ❑ Mental Health Concerns

Yes ❑ No ❑ Wears contact lenses

Yes ❑ No ❑ Wears dental appliance

Yes ❑ No ❑ Hearing problem

Yes ❑ No ❑ Asthma

Yes ❑ No ❑ Trouble breathing during exercise

Yes ❑ No ❑ Heart Condition

Yes ❑ No ❑ Palpitations or Racing Heart

Yes ❑ No ❑ Family history of heart disease

Yes ❑ No ❑ Family history of unexpected death during physical activity

Yes ❑ No ❑ Family history of unexplained death of a young person

Yes ❑ No ❑ Diabetes – Type 1____ Type 2_____

Yes ❑ No ❑ Wears medical information bracelet/necklace
For what purpose? _____

Yes ❑ No ❑ Health problem that would interfere with participation at a swim meet

Yes ❑ No ❑ Has had an illness that lasted more than a week and required medical attention in the past year

Yes ❑ No ❑ Has had injuries requiring medical attention in the past year

Yes ❑ No ❑ Been admitted to hospital in the last year

Yes ❑ No ❑ Surgery in the last year

Yes ❑ No ❑ Presently injured
Injured body part: _____

Yes ❑ No ❑ Vaccinations up to date
Date of last Tetanus Shot:_____

Yes ❑ No ❑ Hepatitis B vaccination

Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)

_____

_____

_____

Medications:_____

Allergies: _____

Medical conditions: _____

Recent injuries: _____

Any information not covered above: _____

_____

I understand that it is my responsibility to keep the team advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child. I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date: _____ Signature of Swimmer: _____

Date: _____ Signature of Parent or Guardian: _____

Disclaimer: Personal information used, disclosed, secured or retained by TIDE Swim Club will be held solely for the purposes for which we collected it.