Lisbon Bullsharks Swim Team 2023-2024
Medical Clearance Form

Name: _____

Age: _____

Date of birth (dd/mm/YYYY): _____

Request Clearance for participating on Swim Team

Has Asthma or needs inhaler for sport activity?

_____yes _____no

Vision test done: _____yes _____no Passed: _____yes _____no

Please state any allergies: _____

Current Medications: _____

_____

_____

Cleared for swimming: _____yes _____no

Restrictions: _____

_____

_____

_____ _____

Provider Signature / Stamp Date