Border Swimming Travel Medical Form

SWIMMER INFORMATION

Swimmer's Name _____ Gender: ☐ Female Male

Address _____ City _____ State _____ Zip _____

PARENT INFORMATION

Parent/Legal Guardian: (**both names please**)

_____

Home Phone Number _____ Work Phone Number _____
Parent 1 Cell _____ Parent 2 Cell _____
Emergency Contact Name _____ Relation to Swimmer_____
Phone Number _____ Address _____
Family Physician Name _____ Dr.'s Office Phone_____
Family Dentist/Orthodontist _____ Dr.'s Office Phone _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, please indicate the carrier or plan name _____ Group # _____
Policy Holder's Name _____ Date of Birth _____
***Please **attach a photocopy** of the front and back of health insurance card.

Please **attach a copy** of a physical form or wellness exam within the last 24 months. Please include most current shot record. Camper's medical history must be CURRENT and SO RECORDED on this form.

General Questions: (Explain "yes" answers below.)

Has/does the participant:	**Yes**	**No**		**Yes**	**No**
Had any recent injury, illness or infectious disease?……	☐	☐	Ever had problems with joints (e.g., knees, ankles)?…..	☐	☐
Have a chronic or recurring illness/condition?……	☐	☐	Ever had back problems? ……	☐	☐
Ever been hospitalized? ……..	☐	☐	Have an orthodontic appliance being brought to camp?.	☐	☐
Ever had surgery……	☐	☐	Have any skin problems (e.g., itching, rash, acne)?…..	☐	☐
Have frequent headaches? ……..	☐	☐	Have diabetes? ……..	☐	☐
Ever had a head injury? ……..	☐	☐	Have asthma? ……	☐	☐
Ever been knocked unconscious? ……..	☐	☐	Had mononucleosis in the past 12 months? ……	☐	☐
Wear glasses, contacts or protective eyewear? ….	☐	☐	Had problems with diarrhea/constipation? …….	☐	☐
Ever had frequent ear infections? ……	☐	☐	Have problems with sleepwalking? ……	☐	☐
Ever passed out during or after exercise? ……	☐	☐	If female, have an abnormal menstrual history? ……	☐	☐
Ever been dizzy during or after exercise? ……	☐	☐	Have a history of bed-wetting? ……	☐	☐
Ever had seizures? ……	☐	☐	Ever had an eating disorder? ……	☐	☐
Ever had chest pain during or after exercise? …….	☐	☐	Ever had emotional difficulties for which professional help was sought? ……..	☐	☐
Ever had high blood pressure? ……	☐	☐	Ever been diagnosed with a heart murmur? ……..…	☐	☐

Please explain any "yes" answers:

_____

_____

Please list ALL known **ALLERGIES**…. Describe reaction and management of the reaction.
Medication, Food, or Other Allergies: (include insect stings, hay fever, animal dander, etc.)

_____

Medications Being Taken on a Routine Basis

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire trip. Keep medication in the **original packaging/bottle** that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. Please be advised that all medications will be kept with coaches, with exceptions to asthma and Epi pen meds.

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for Taking _____
Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for Taking _____
Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for Taking _____
Med #4 _____ Dosage _____ Specific times taken each day _____
Reason for Taking _____
Identify any medications taken during the school year that participant does/may not take during the summer:
_____

Please check the following medications that may be administered to your swimmer. Please include any special instructions.

- Tylenol _____
- Motrin _____
- Pepto _____
- Zyrtec _____
- Allegra _____
- Claritin _____
- Benadryl _____
- Cough Meds _____
- Dayquil (over 12 only) _____
- Nyquil (over 12 only) _____

Are there any restrictions on your swimmer? _____
_____ Does your camper require any special supervision? _____

Parent/Guardian Authorizations: This health history is correct and complete as far as we know. The person herein described has permission to engage in all travel activities. I hereby give permission to the travel team to administer prescribed medications, over the counter meds as listed above, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the travel team to arrange necessary related transportation for my swimmer. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the travel team to secure and administer treatment, including hospitalization, injections, anesthesia, or surgery for me or my swimmer named above.

Signature of parents/guardian or adult traveling.

_____ Date _____
_____ Date _____

IMPORTANT: This form must be completed prior to travel.

Additional Notes:_____

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