

Whitney Point Swim Club  
Medical History Form

Swimmer's Name \_\_\_\_\_ Date \_\_\_\_\_

Please circle YES or NO and provide additional details where requested.

1. Is the swimmer allergic to any medication (aspirin, penicillin, sulfa, etc)? Please List: _____	NO	YES
2. Has the swimmer ever had an epileptic seizure?	NO	YES
3. Has the swimmer ever been treated for diabetes?	NO	YES
4. Has the swimmer ever had high blood pressure?	NO	YES
5. Has the swimmer ever been told by a doctor that they have asthma? Please List Medications:	NO	YES
6. Does the swimmer wear glasses or contacts during practice or competition?	NO	YES
7. Does the swimmer have any heart conditions (murmur, irregular heartbeat, etc)?	NO	YES
8. Is there any other condition that the WPSC staff should be aware of (ulcers, pregnancy, food or insect allergies, tendonitis, etc)? Please List:	NO	YES
9. Please list any other medications we should be aware of:		
10. Please list any other medications we should be aware of:		

The questions on this form have been answered completely and truthfully, to the best of my knowledge.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_