

ATHLETE PARTICIPATION, MEDICAL HISTORY QUESTIONNAIRE & AUTHORIZATION

***All information is kept confidential**

ATHLETE NAME (LAST, FIRST, MI): _____

DATE OF BIRTH : _____ / _____ / _____ SEX: F / M

STREET ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME TEL: (_____) _____ - _____ CELL #: (_____) _____ - _____

PARENT(S)/LEGAL GUARDIAN(S) NAME:

NAME: _____

E-MAIL ADDRESS _____ @ _____

HOME TEL: (_____) _____ - _____ CELL #: (_____) _____ - _____

EMERGENCY CONTACT(S):

(1) _____ TEL: (_____) _____ - _____

(2) _____ TEL: (_____) _____ - _____

***EACH QUESTION MUST BE ANSWERED:**

YES NO HAS THE ATHLETE EVER HAD HOSPITALIZATION, SURGERY, INJURY, OR SERIOUS MEDICAL ILLNESS?

IF YES, PLEASE DESCRIBE: _____

YES NO IS THE ATHLETE NOW UNDER THE CARE OF A PHYSICIAN OR TAKEN ANY MEDICATION?

IF YES, PLEASE DESCRIBE: _____

YES NO HAS ANY PHYSICIAN EVER RECOMMENDED OR DO YOU FEEL THAT THERE SHOULD BE LIMITS PLACED ON PARTICIPATION IN COMPETITIVE SPORTS?

IF YES, PLEASE DESCRIBE: _____

YES NO DOES THIS ATHLETE HAVE ANY KNOWN ALLERGIES TO MEDICATION?
IF YES, PLEASE DESCRIBE: _____

YES NO HAS THIS ATHLETE EVER BLACKED OUT OR LOST CONSCIOUSNESS DURING PHYSICAL ACTIVITY?

IF YES, PLEASE DESCRIBE: _____

I/WE HEREBY CONSENT TO THE PARTICIPATION OF THE ABOVE NAMED ATHLETE IN THE LANSING SWIM ORGANIZATION PROGRAM.

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PARENT / LEGAL GUARDIAN _____ DATE __/__/2010

EMERGENCY MEDICAL AUTHORIZATION

I, _____ PARENT(S) / LEGAL GUARDIAN OF _____, BORN ON _____, DO HEREBY GIVE MY CONSENT TO LANSING SWIM ORGANIZATION, TO SECURE, DISCUSS AND AUTHORIZE SUCH EMERGENCY MEDICAL TREATMENT AS THE ABOVE NAME MIGHT REQUIRE WITH PHYSICIANS, HOSPITALS AND/OR OTHER HEALTHCARE PROVIDER. I ALSO AGREE TO PAY ALL THE COSTS AND FEES CONTINGENT ON EMERGENCY MEDICAL CARE OR TREATMENT FOR MY CHILD AS SECURED OR AUTHORIZED UNDER THIS CONSENT.

NOTE: EVERY EFFORT WILL BE MADE TO NOTIFY THE PARENT(S)/LEGAL GUARDIAN, IN CASE OF AN EMERGENCY. IN THE EVENT OF AN EMERGENCY, IT WOULD BE NECESSARY TO HAVE THE FOLLOWING INFORMATION:

FAMILY PHYSICIAN: _____ TEL: (____) ____ - _____

PREFERRED HOSPITAL: _____

SIGNATURE OF PARENT / LEGAL GUARDIAN _____

PRINTED NAME: _____

TELEPHONE: (____) ____ - _____ CELLULAR: (____) ____ - _____

DATED: ____ / ____ / 2010