



Hickory Willow Swim Association Medical Form



FAMILY NAME _____

ADDRESS _____ CITY _____

PHONE () _____ EMERGENCY PHONE () _____

MEDICAL HISTORY - PLEASE ANSWER **YES OR NO** TO THE FOLLOWING QUESTIONS FOR EACH SWIMMER LISTED. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

		SWIMMERS NAMES				
Has swimmer ever been treated for or had any known indication of the following:		Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
1	Dizziness, fainting, convulsions, headaches, paralysis, stroke, or other mental or nervous disorders?					
2	Disorder of the eyes, ears, nose or throat?					
3	Shortness of breath, persistent hoarseness or cough, blood spitting, pleurisy, asthma, tuberculosis, or other respiratory disorder?					
4	Chest pain, high blood pressure, rheumatic fever, heart murmur, hearth attack, or other disorder of the heart or blood vessels?					
5	Hernia, appendicitis, colitis, diverticulitis, recurrent indigestion, or other disorder of the stomach, liver, intestines, or gallbladder?					
6	Diabetes, thyroid, or other enocrine disorder?					
7	Allergies, anemia, or other disorder of the blood?					
8	Disorder of skin, lymph glands cyst, tumor, or cancer?					
9	Have you been exposed to anyone who has tested positive, or have you yourself tested positive for HIV-AIDS virus?					
10	Are you presently under observation, or taking medication/treatments for any of the above?					

If you have answered YES to any question, please explain in detail on the reverse side of this form.