

MEDICAL HISTORY QUESTIONNAIRE

Medical History Questionnaire for First Swimmer

Swimmer's Name: _____

Please Circle:

- Yes No Has the athlete ever had hospitalization, surgery, injury, or any serious medical illness?
Yes No Is the athlete now under the care of a physician or taking any medication?
Yes No Has any physician ever recommended or do you feel there should be limits placed on participation in competitive sports?
Yes No Does the athlete have any known allergies to medication?
Yes No Does the athlete wear glasses or contact lenses? Date of last eye exam: _____
Yes No Has this athlete ever blacked out or lost consciousness during physical activity?

Please elaborate on any questions to which you have answered YES and/or provide any other medical related information about which the Club needs to be informed (If more space is needed, please continue on the back of this form):

Medical History Questionnaire for Second Swimmer

Swimmer's Name: _____

Please Circle:

- Yes No Has the athlete ever had hospitalization, surgery, injury, or any serious medical illness?
Yes No Is the athlete now under the care of a physician or taking any medication?
Yes No Has any physician ever recommended or do you feel there should be limits placed on participation in competitive sports?
Yes No Does the athlete have any known allergies to medication?
Yes No Does the athlete wear glasses or contact lenses? Date of last eye exam: _____
Yes No Has this athlete ever blacked out or lost consciousness during physical activity?

Please elaborate on any questions to which you have answered YES and/or provide any other medical related information about which the Club needs to be informed (If more space is needed, please continue on the back of this form):

Medical History Questionnaire for Third Swimmer

Swimmer's Name: _____

Please Circle:

- Yes No Has the athlete ever had hospitalization, surgery, injury, or any serious medical illness?
Yes No Is the athlete now under the care of a physician or taking any medication?
Yes No Has any physician ever recommended or do you feel there should be limits placed on participation in competitive sports?
Yes No Does the athlete have any known allergies to medication?
Yes No Does the athlete wear glasses or contact lenses? Date of last eye exam: _____
Yes No Has this athlete ever blacked out or lost consciousness during physical activity?

Please elaborate on any questions to which you have answered YES and/or provide any other medical related information about which the Club needs to be informed (If more space is needed, please continue on the back of this form):
