MEDICAL HISTORY QUESTIONAIRE

East Lyme All Star Sports School

Name:____
Last First Middle

Address:____

Parent(s) Name(s)____

Address (if different from swimmer):_____________________________________

____

Date of Birth:___________________________ Sex________________________
Emergency Contact:______________________ Phone (w)_________________
Family Physician_________________________ Phone_____________________

Please circle "Yes" or "No" and provide additional details where requested. Add extra sheets if needed.

YES NO 1. Has this swimmer ever had hospitalization, surgery , injury or serious medical illness?____
____

YES NO 2. Is this swimmer under the care of a physician?

YES NO 3. Is this swimmer currently taking any medication ?__________________
____

YES NO 4. Has any physician ever recommended or do you feel that there should be any limits placed on participation in competitive sports?

YES NO 5. Does this swimmer have any know allergies to medication?__________
____

YES NO 6. Does this swimmer wear glasses or contact lenses?

YES NO 7. Does this swimmer wear contact lenses while swimming?

YES NO 8. Has this swimmer ever blacked out, lost consciousness, or complained of dizziness during practice or competition?(explain)_______________
____

We consent to the participation of the above named swimmer in the East Lyme All Star Sports School Program.

____ ________________________
Mother's signature Date

____ ________________________
Father's Signature Date