Unley Swimming Club

New Swimmer & Medical Form

PERSONAL INFORMATION

Full Name: ______________________________
First Name(s) *Family Name*

Date Of Birth: ______________________________

Address: ______________________________
Street Address

____
Suburb *Post Code*

Home Phone: ______________ **Swimmer Mobile (if applicable):** ______________

Parent Name (1): ______________________________

Parent Mobile (1): ______________ **Parent (1) Date Of Birth:** ______________

Email (1): ______________________________

Parent Name (2): ______________________________

Parent Mobile (2): ______________ **Parent (2) Date Of Birth:** ______________

Email (2): ______________________________

Note: All email addresses will be added to our mailing list.

EMERGENCY CONTACT (Different to above parent contact details)

Full Name: ______________________________
First Name(s) *Family Name*

Primary Phone: ______________ **Alternate Phone:** ______________

Relationship: ______________________________

MEDICAL DETAILS

Medicare No.: ______________ **Expiry Date:** ______________

Private Health Insurance: Fund Name: ______________ **Membership No.:** ______________

Table: ______________________________

Ambulance Cover? ______________ **Membership No.:** ______________

Family Doctor's Name: ______________________________

Clinic Name: **Phone No.:**

PLEASE COMPLETE THE MEDICAL INFORMATION ON THE BACK OF THIS FORM

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OTHER INFORMATION

Previous Swimming: ____________________ **Level Attained:** ____________________

How did you hear about us?

☐ Website ☐ Facebook ☐ Promotional ☐ Referral

☐ Other (please specify): ____________________

SWIMMER MEDICAL INFORMATION

Please tick if the swimmer suffers from any of the following:

☐ Allergies	☐ Blood Pressure	☐ Epilepsy	☐ Hay Fever
☐ Nose Bleeds	☐ Asthma	☐ Diabetes	☐ Fainting
☐ Eczema	☐ Headaches	☐ Heart Condition	☐ Fits or Blackouts

☐ Other (please specify): ____________________

If YES to allergies please list ____________________

If YES to asthma please list treatment ____________________

If YES to diabetes please list treatment ____________________

If Yes to epilepsy please list treatment ____________________

If Yes to any others please give further details ____________________

Date of Last TETANUS injection ____________________

If the swimmer is on any medication please list (name, dose, frequency, route, possible side effects) ____________________

If aware of any medical emergency that could occur please expand on treatment required to prevent and treat. Attach treatment plan if applicable ____________________

Please expand on any other relevant information relating to the health of the swimmer if applicable ____________________

SWIMMER MEDICAL INFORMATION

Should it be necessary for our/my child to have medical, dental or optical treatment whilst participating in some aspect of the Club swimming program and we/I cannot be contacted or advised, permission is given for the Coach or Team Manager or Committee Member to use their judgment in obtaining the best possible service required.

SIGNED Parent/Guardian (1) or Swimmer if Over 18: ____________________

SIGNED Parent/Guardian (2): ____________________

Date: ____________________