Central Chesapeake Swimming
MEDICAL INFORMATION FORM

Swimmer's Name _____
First Middle Last

Date of Birth: _____ **Age:** _____

Parents'/Guardians' Name(s): _____
_____

Address:_____
(Street)
_____
(City) (State) (Zip Code)

Parent/Guardian Phone Number: **Home** _____
Work _____
Cell _____
E-Mail _____

In case of emergency (Parent/Guardian is not available), please contact the following:

_____
(Name) (Relationship) (Phone)

Physician's Name: _____ **Phone:** _____

List Allergies: _____
_____
_____

Medications: _____
_____

Please check: In case of emergency, you do _____ do not ____have permission to seek medical attention for my child.

Parent/Guardian Signature: **Date:** _____