

**Medical Information/Emergency Contacts**  
(Please print)

Swimmers Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Last four SSN \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Last four SSN \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone \_\_\_\_\_

**EMERGENCY CONTACTS: LOCAL**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

**MEDICAL HISTORY:**

**Allergies:**      No      Yes      If yes, please give specific details

Drugs                        \_\_\_\_\_

Pollen                       \_\_\_\_\_

Food                         \_\_\_\_\_

Insect                       \_\_\_\_\_

Other \_\_\_\_\_

**MEDICATION:**

Are you currently taking medication?       YES       NO

If yes, please list the medication(s): \_\_\_\_\_

**HOSPITALIZATION:**

Have you ever been hospitalized?             YES      NO

If yes, please give 1) Date of hospitalization: \_\_\_\_\_  
(Month/Day/Year)

2) Reason for hospitalization \_\_\_\_\_

**INSURANCE/FINANCIAL RESPONSIBILITY:**

**If insurance is other than Tricare or Guarantor of bill is other than patient or parent, please fill out insurance form.**