

Fairport Area Swim Team (FAST)

Health Information & Emergency Contacts and Release 2008-09

PLEASE PRINT ALL INFORMATION CLEARLY

Swimmer's Name: _____

Does your swimmer...		If yes, please describe (include how it may affect swimmer's performance at practice or meets) (may continue on back)
1. Have any allergies to medicine, foods, etc.?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
2. Take any daily or frequent medicines?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
3. Wear contacts/glasses or have any problems with the eyes?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
4. Wear a hearing aid or have any problems with hearing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
5. Have problems with swimmer's ear or inner ear infections?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
6. Have any problems breathing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes
7. Have any heart disease, murmur, or irregular heartbeat?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
8. Have any problems with use of the neck, back, arms, or legs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
9. Have any learning, behavioral, or mental health needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
10. Have ADD or ADHD?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
11. Have problems with weight for age and height?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Overweight? <input type="checkbox"/> No <input type="checkbox"/> Yes Underweight? <input type="checkbox"/> No <input type="checkbox"/> Yes
12. Have diabetes?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Insulin-dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes

Are there any other health problems, concerns, and/or illnesses that may affect your swimmer during practices and meets?

Swimmer's Doctor: _____ Phone: _____

Swimmer's Dentist: _____ Phone: _____

Swimmer's Health Insurance: _____

Subscriber's Name: _____ Preferred Hospital: _____
(if possible)

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In the event of an emergency during a practice or meet, please list, in order, three people to contact:

1st Contact: Name: _____ Relationship: _____

Phone Number(s): _____

2nd Contact: Name: _____ Relationship: _____

Phone Number(s): _____

3rd Contact: Name: _____ Relationship: _____

(NOT A PARENT)

Phone Number(s): _____

Emergency Release

I(we), being the parent(s)/legal guardian(s) of _____, appoint the coaches of the Fairport Area Swim Team (FAST) to act in my/our behalf in authorizing necessary emergency medical, dental, surgical care, and hospitalization required to protect the swimmer's life or health while participating in any practices and meets and in any travel to and from local and out-of-town meets during the 2008-2009 season. I(we) understanding that all reasonable safety procedures will be followed. I(we) will not hold the coaches of FAST nor any chaperone or volunteer working with or traveling with a FAST group personally liable for any accident or injury that may occur.

To the Attending Physician or Hospital

Permission is granted for you, at the discretion of the FAST coaches or chaperones, to perform whatever care is necessary for the welfare of my child until such time as you are able to reach me(us) personally.

Parent/Guardian: _____ Date: _____
(Signature)