



**BLUE LAKE Y SWIM CLUB****SWIMMER REGISTRATION AND MEDICAL INFORMATION FORM 2018-2019****SWIMMER MEDICAL DETAILS**

Please tick if the swimmer suffers any of the following:

- |  |  |  |                                    |                                      |
|--|--|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Blood Pressure    | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Headaches   |
| <input type="checkbox"/> Reaction to Drugs | <input type="checkbox"/> Fits or Blackouts | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Other     |                                      |

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

**PERMISSION FOR ATTAINMENT OF TREATMENT**

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.

We/I understand that any insurance costs incurred will be our/my responsibility.

We/I understand that any medical costs incurred will be our/my responsibility.

If there is any change in our/my child medical condition it is our/my responsibility to notify the Club and update the Medical Information Form and treatment plan

SIGNED: \_\_\_\_\_ (Parent/Guardian One or Swimmer if 18 or over)

DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_ (Parent/Guardian Two)      DATE: \_\_\_\_\_

I have accepted the conditions of the BLY Pick Up Drop Off Policy *(please tick)*

Payment Plan – Please see the BLY Treasurer if a payment plan is needed to pay for seasonal fees.