

Fairchild AFB Aquatic Program
Novice Swim Team
Medical Information Form
 Confidential Information

Name		Age:
Resident Address:		Weight:
Squadron:		Height:
City:	State:	Zip:
Resident Phone:		Duty Phone:

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

Name of Emergency Contact:	
Relationship:	
Address:	
City:	State:
Zip:	Phone # :

Please answer the following questions to the best of your ability. The information that you can provide will help inform professionals in the event of an emergency, i.e. Emergency Medical Professionals, Police, etc.

Statement of present health status:

Statement of present physical condition:

Have you ever HAD or HAVE a problem with ALLERGIES: (Please circle Yes or No.)

YES or NO Pollen, food, or drug allergies.

YES or NO Allergies to insect bites.

If yes, please explain.

List any medical problems, illness, injuries, or chronic conditions that you have been treated for by clinics, physicians, or other practitioners within the last five years:

List any illness or injury other than those already noted:

List any medication that you are currently taking:

HAVE YOU EVER HAD OR HAVE ANY PROBLEMS WITH ANY OF THE FOLLOWING: (Please circle Yes or No. If yes, please explain in area below)

- YES or NO Asthma
- YES or NO Diabetic
- YES or NO Dizziness/ Fainting Spells
- YES or NO Epilepsy
- YES or NO Frequent/ Severe Headaches
- YES or NO Hay Fever
- YES or NO Heart Trouble
- YES or NO Hypoglycemia
- YES or NO Kidney/ Liver
- YES or NO Rupture/ Hernia
- YES or NO Severe Motion Sickness
- YES or NO Back Pain/ Spinal Injury
- YES or NO Shortness of Breath
- YES or NO Stomach/ Intestinal/ Ulcers
- YES or NO Swollen/ Painful Joints
- YES or NO Hypothermia
- YES or NO Fear of High Places
- YES or NO Fear of Water
- YES or NO Can you swim

If yes, please explain.

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION, AND THAT THE INFORMATION CONTAINED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE USE AND ARE OF ANY PERSONAL MEDICATIONS AND/OR MEDICAL REQUIREMENTS.

Signature

Date:
