MONTCLAIR YMCA DOLPHINS SWIM TEAM HEALTH FORM

NAME_____ DATE OF BIRTH_____ AGE_____ SEX_____

PARENT OR GUARDIAN_____

STREET_____ CITY_____ STATE_____ ZIP_____

If not available in an emergency, notify:

1) Name_____ Phone_____

Address_____

2) Name_____

Address_____

Family Physician_____ Phone_____

Address_____

HEALTH HISTORY (Check and give approximate dates)

Ear Infections_____	Chicken Pox_____	Allergies
Rheumatic Fever_____	Measles_____	Hay Fever_____
Convulsions_____	Mumps_____	Penicillin_____
Diabetes_____	Asthma_____	Insects_____
Do you wear contacts?_____		Other _____

Operations of Serious Injuries, Including dates:_____

_____

Other Diseases or Restrictions: _____

_____

Currently taking any medication? If so what?_____

_____

Insurance Company_____ Policy #:_____

Physicians Name:_____ Phone #:_____

Date of last physical exam:_____

Parent/Guardian's authorization: I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct. I give permission for _____ to participate on the Montclair YMCA Swim Team.

Parent/Guardian Signature:_____ Date:_____