

WHEATON SWIM CLUB
SHORT COURSE & LONG COURSE 2006-07 SEASONS
Swimmer Blanket Permission / Health History (Page 1 of 2)

(Note: returning swimmers should complete this form ONLY if information has changed from the winter season).

I hereby give my consent for my child(ren) to participate in the Wheaton Swim Club

Children(s) Name(s): _____ Children(s) Phone: (H) _____
 Address: _____ City: _____ State: ___ Zip _____

Mother's Name: _____ Mother's Phone: (H) _____ (W) _____
 Address: _____ City: _____ State: ___ Zip _____
 Mother's Occupation _____

Father's Name: _____ Father's Phone: (H) _____ (W) _____
 Address: _____ City: _____ State: ___ Zip _____
 Father's Occupation _____

<u>Child's Name</u>	<u>School Name</u>	<u>Fall 2005 Grade</u>	<u>Age</u>	<u>Birthdate</u>
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____

PERSON(S) TO BE NOTIFIED IN EMERGENCY WHEN PARENT CANNOT BE REACHED:		
NAME: _____	Relationship: _____	Phone: () _____
NAME: _____	Relationship: _____	Phone: () _____

The undersigned on behalf of themselves and their children indemnifies and holds harmless the Wheaton Swim Club, the College DuPage, Wheaton College, and any other facility or its agents used by the above, for any injury to them, their children, or others, and for any other liability arising from their child's participation in this program.

Parent/Guardian Signature _____ **Date:** _____
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*In the event of an emergency and I cannot be reached, I give my permission to a licensed physician or hospital selected by the person in charge to hospitalize, secure proper treatment, anesthesia or surgery for the child named on this form. I also consent to routine, non-surgical medical care.*  
 My child  may  may not receive Tylenol.

**Parent/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_  
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WHEATON SWIM CLUB
SHORT COURSE & LONG COURSE 2005-06 SEASONS
Swimmer Blanket Permission / Health History (Page 2 of 2)

CHILD #1	CHILD #2	CHILD #3
Name:	Name:	Name:
<i>General Health Information</i>	<i>General Health Information</i>	<i>General Health Information</i>
1. Eyes: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts	1. Eyes: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts	1. Eyes: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
2. Ears: <input type="checkbox"/> Tubes <input type="checkbox"/> Hearing Aid	2. Ears: <input type="checkbox"/> Tubes <input type="checkbox"/> Hearing Aid	2. Ears: <input type="checkbox"/> Tubes <input type="checkbox"/> Hearing Aid
3. Heart Trouble: <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Heart Trouble: <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Heart Trouble: <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Inhaler Used: <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Inhaler Used: <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Inhaler Used: <input type="checkbox"/> Yes <input type="checkbox"/> No
6. List Allergies:	6. List Allergies:	6. List Allergies:
7. List Past Operations:	7. List Past Operations:	7. List Past Operations:
8. List Past Serious Illnesses:	8. List Past Serious Illnesses:	8. List Past Serious Illnesses:
9. List Medications:	9. List Medications:	9. List Medications:
<i>Are your child's shot up to date?</i>	<i>Are your child's shot up to date?</i>	<i>Are your child's shot up to date?</i>
1. Diphtheria: <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Diphtheria: <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Diphtheria: <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Tetanus: <input type="checkbox"/> Yes/date <input type="checkbox"/> No	2. Tetanus: <input type="checkbox"/> Yes/date <input type="checkbox"/> No	2. Tetanus: <input type="checkbox"/> Yes/date <input type="checkbox"/> No
3. Whooping Cough: <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Whooping Cough: <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Whooping Cough: <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Boosters: <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Boosters: <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Boosters: <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Polio Vaccine: <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Polio Vaccine: <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Polio Vaccine: <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Measles Vaccine:	6. Measles Vaccine:	6. Measles Vaccine:
Rubella (hard): <input type="checkbox"/> Yes <input type="checkbox"/> No	Rubella (hard): <input type="checkbox"/> Yes <input type="checkbox"/> No	Rubella (hard): <input type="checkbox"/> Yes <input type="checkbox"/> No
Rubella (3-day): <input type="checkbox"/> Yes <input type="checkbox"/> No	Rubella (3-day): <input type="checkbox"/> Yes <input type="checkbox"/> No	Rubella (3-day): <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Mumps: <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Mumps: <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Mumps: <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Tuberculin: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	8. Tuberculin: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	8. Tuberculin: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<i>Has your child had the following?</i>	<i>Has your child had the following?</i>	<i>Has your child had the following?</i>
1. Chicken Pox: <input type="checkbox"/> Yes/age <input type="checkbox"/> No	1. Chicken Pox: <input type="checkbox"/> Yes/age <input type="checkbox"/> No	1. Chicken Pox: <input type="checkbox"/> Yes/age <input type="checkbox"/> No
2. Mumps: <input type="checkbox"/> Yes/age <input type="checkbox"/> No	2. Mumps: <input type="checkbox"/> Yes/age <input type="checkbox"/> No	2. Mumps: <input type="checkbox"/> Yes/age <input type="checkbox"/> No
3. Measles: <input type="checkbox"/> Yes/age <input type="checkbox"/> No	3. Measles: <input type="checkbox"/> Yes/age <input type="checkbox"/> No	3. Measles: <input type="checkbox"/> Yes/age <input type="checkbox"/> No
4. Other Diseases: <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Other Diseases: <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Other Diseases: <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list diseases:	If yes, list diseases:	If yes, list diseases:
<i>Health Conditions</i>	<i>Health Conditions</i>	<i>Health Conditions</i>
Please describe any health conditions present which should be considered:	Please describe any health conditions present which should be considered:	Please describe any health conditions present which should be considered:

PLEASE GIVE ALL MEDICATIONS TO THE COACH OR ADULT IN CHARGE

Physician's Name: _____ *Phone ()* _____

Any child who has had an operation or serious illness since their last annual health exam must secure a written statement from their doctor giving permission to participate in this program.

Parent/Guardian Signature: _____ **Date:** _____