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

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_____________________________

	Child's Name	School Name	Fall 2005 Grade	Age	Birthdate
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 2006-07 SEASONS
Swimmer Blanket Permission / Health History (Page 2 of 2)

CHILD #1	CHILD #2	CHILD #3
Name:	**Name:**	**Name:**
General Health Information	***General Health Information***	***General Health Information***
1. Eyes: ☐ **Glasses** ☐ **Contacts**	**1. Eyes:** ☐ **Glasses** ☐ **Contacts**	**1. Eyes:** ☐ **Glasses** ☐ **Contacts**
2. Ears: ☐ **Tubes** ☐ **Hearing Aid**	**2. Ears:** ☐ **Tubes** ☐ **Hearing Aid**	**2. Ears:** ☐ **Tubes** ☐ **Hearing Aid**
3. Heart Trouble: ☐ **Yes** ☐ **No**	**3. Heart Trouble:** ☐ **Yes** ☐ **No**	**3. Heart Trouble:** ☐ **Yes** ☐ **No**
4. Asthma: ☐ **Yes** ☐ **No**	**4. Asthma:** ☐ **Yes** ☐ **No**	**4. Asthma:** ☐ **Yes** ☐ **No**
5. Inhaler Used: ☐ **Yes** ☐ **No**	**5. Inhaler Used:** ☐ **Yes** ☐ **No**	**5. Inhaler Used:** ☐ **Yes** ☐ **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:**
Are your child's shot up to date?	***Are your child's shot up to date?***	***Are your child's shot up to date?***
1. Diphtheria: ☐ Yes ☐ No	**1. Diphtheria:** ☐ Yes ☐ No	**1. Diphtheria:** ☐ Yes ☐ No
2. Tetanus: ☐ Yes/date______ ☐ No	**2. Tetanus:** ☐ Yes/date______ ☐ No	**2. Tetanus:** ☐ Yes/date______ ☐ No
3. Whooping Cough: ☐ Yes ☐ No	**3. Whooping Cough:** ☐ Yes ☐ No	**3. Whooping Cough:** ☐ Yes ☐ No
4. Boosters: ☐ Yes ☐ No	**4. Boosters:** ☐ Yes ☐ No	**4. Boosters:** ☐ Yes ☐ No
5. Polio Vaccine: ☐ Yes ☐ No	**5. Polio Vaccine:** ☐ Yes ☐ No	**5. Polio Vaccine:** ☐ Yes ☐ No
6. Measles Vaccine:	**6. Measles Vaccine:**	**6. Measles Vaccine:**
Rubella (hard): ☐ Yes ☐ No	**Rubella (hard):** ☐ Yes ☐ No	**Rubella (hard):** ☐ Yes ☐ No
Rubella (3-day): ☐ Yes ☐ No	**Rubella (3-day):** ☐ Yes ☐ No	**Rubella (3-day):** ☐ Yes ☐ No
7. Mumps: ☐ Yes ☐ No	**7. Mumps:** ☐ Yes ☐ No	**7. Mumps:** ☐ Yes ☐ No
8. Tuberculin: ☐ Positive ☐ Negative	**8. Tuberculin:** ☐ Positive ☐ Negative	**8. Tuberculin:** ☐ Positive ☐ Negative
Has your child had the following?	**Has your child had the following?**	**Has your child had the following?**
1. Chicken Pox: ☐Yes/age___ ☐No	**1. Chicken Pox:** ☐Yes/age___ ☐No	**1. Chicken Pox:** ☐Yes/age___ ☐No
2. Mumps: ☐Yes/age___ ☐No	**2. Mumps:** ☐Yes/age___ ☐No	**2. Mumps:** ☐Yes/age___ ☐No
3. Measles: ☐Yes/age___ ☐No	**3. Measles:** ☐Yes/age___ ☐No	**3. Measles:** ☐Yes/age___ ☐No
4. Other Diseases: ☐Yes ☐No	**4. Other Diseases:** ☐Yes ☐No	**4. Other Diseases:** ☐Yes ☐No
If yes, list diseases:	**If yes, list diseases:**	**If yes, list diseases:**
Health Conditions	***Health Conditions***	***Health Conditions***
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:________________