

Medical Conditions (Heart, Diabetes, Etc.) INT:
BLOOD TYPE:

Please Print: _____

Allergies (Penicillin, Sulfa, Etc.)

I am taking the following medications: Please Print:

Insurance Information

Name : _____ **Phone:** _____

Medicare:
Do you have Medicare? YES NO

Secondary Insurance :

Primary Care Physician **Please Print:**

DR.

ADDRESS:

CITY : _____ **STATE :** _____ **ZIP CODE:** _____

PHONE:

If it is necessary you will be required to wear an approved floatation device

After Sides 1 & 2 have been completed, return form to your **S.W.I.M., inc.** Chapter Coordinator