

**Zone C Medical Form
Wisconsin Swimming inc.**

**PART ONE:
CONSENT FOR MEDICATION ADMINISTRATION
and MEDICAL TREATMENT**

TO THE PARENT(S) OR LEGAL GUARDIAN:

Your son, daughter, or ward will be at or under the age of 18 while at the Zone C swim meet and traveling to and from the meet as a member of Team Wisconsin, it is Wisconsin Swimming inc. policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by a zone C chaperone with your instructions.

All medications must be in a medicine bottle and labeled with the swimmer's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below:

_____ No medication has been brought to Zone meet.

_____ I want the medication or medical devices self-administered.

_____ I want the medication or medical device administered a Zone Chaperone. However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

_____ Name of Medication (s)

_____ Prescribing Doctor

_____ Doctor's Phone #

_____ Amount to be taken

..... How is it taken?

..... When to be administered

_____ Day(s) to be taken

..... Special Instructions

- Your son, daughter, or ward will be at or under the age of 18 years while at the Zone C meet, it is our policy to secure your consent for medical treatment.
- By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
- By signing below you agree to hold harmless and indemnify USA Swimming as well as Wisconsin Swimming inc. their officers, employees and agents, from any and all liability, loss, damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the Zone C meet

_____ Participant Name (Please Print)

_____ USA Swim club

_____ Signature of Parent or Guardian

_____ Date

PART TWO: HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:		Zone C Meet	
Full Home Address:		Home Telephone Number:	Date of Birth: ____/____/____ Sex: M F
			Height: _____ Weight: _____
Parent/Guardian Name:	Relationship:		Does participant have allergic reactions to: <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No Other Antibiotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medicine (type) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Insect Bites/Stings _____
Address (if different than above)	Home Telephone Number:(if different than above)		
	Parent/Guardian Work Telephone:		
Alternate contact in the event that the Parent/Guardian cannot be contacted during an injury or illness. (Name, Relationship, Address, and Telephone Number)			Does participant take medication on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Identify _____ (consent for medication administration must be signed on reverse.)
Physician: _____ Telephone: _____ Insurance Co.: _____ Policy No.: _____			Has participant had or presently experiencing: <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures/Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Injury/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Menstrual Difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Emotional Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Neck/Back Pain/Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer Other: _____
Immunization Record			
* MMR (measles, mumps, rubella)			
Dose 1-Immunization at age 1		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dose 2		<input type="checkbox"/> Yes <input type="checkbox"/> No	
* Tetanus-Diphtheria		<input type="checkbox"/> Yes <input type="checkbox"/> No	
* Year of last tetanus boost (must be within last 10 years)			
Has participant ever had major surgery or been hospitalized?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Please explain any significant operations, accidents or illnesses, and last medical attention and reason:			
Does the participant have any physical condition(s) requiring special considerations? Explain.			
A physical examination within 24 months of the camp/event is recommended. Date of participant's last physical examination: _____			