

MEDICAL FORM

TO BE COMPLETED BY THE PARENT / LEGAL GUARDIAN OF THE PARTICIPANT

PARTICIPANT'S DETAILS:

Full Name:			
Date of birth:		Cell No:	
ID Number:			

FATHER / GAURDIAN DETAILS:

MOTHER / GUARDIAN DETAILS:

First Names:		First Names:	
Surname:		Surname:	
Tel (w):		Tel (w):	
Cell No:		Cell No:	
Email address:		Email address:	

ALTERNATIVE CONTACT PERSON:

MEDICAL AID DETAILS:

Name:		Medical Aid Scheme:	
Relation to Participant:		Main Member:	
Tel (w):		Type of Fund:	
Cell No:		Fund Number:	

FAMILY DOCTOR DETAILS:

Name:	Tel no:
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MEDICAL CONDITION OF PARTICIPANT (mark X where applicable)

ADHA	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Other Serious	<input type="checkbox"/>

If any of the above are marked, please give details including medication that is being taken	

Any other minor medical problems that you feel we need to be aware of? Give details	

Do you give your consent for the administration of first aid, antiseptic cream, elastoplasts bandages or Panado, if deemed necessary by the swim instructor and as per the prescribed usage and dosage?

Name & Signature

By Parent / Guardian: _____ / _____

Date: _____