

Richmond Swims/East Bay Regional Park District Personal Health & Medical History

Date/group: _____

Name of Swimmer: _____ Middle Initial: _____
Date of birth: _____ Age: _____
Home Address: _____ Zipcode: _____
Phone: _____ School: _____
Email: _____

Name of parents or guardian #1 _____
Home Address: _____
Home Phone: _____
Business Address: _____
Business Phone: _____ Cell phone/Pager: _____
Email: _____

Name of parents or guardian #2 _____
Home Address: _____
Home Phone: _____
Business Address: _____
Business Phone: _____ Cell phone/Pager: _____
Email: _____

If person(s) named above is not available in case of an emergency, notify _____
Name: _____ Relationship: _____
Phone: _____
Name: _____ Relationship: _____
Phone: _____

Name of personal Physician: _____ Physician Phone: _____
Personal health/accident insurance carrier _____
Policy number: _____

Name of Dentist: _____ Phone _____
Allergies: Food, medicines, insects, etc _____

Please include any relevant information that will better allow us to coach your child: _____

Does your child have an Individualized Education Plan (IEP): _____

*Address, home phone and email will be used on the Sailfish roster unless asked not to.

Check here if you do not want to be added to the team roster:

IN CASE OF EMERGENCY, I understand every effort will be made to contact me (if an adult, my spouse or next of kin.) In the event I cannot be reached, I hereby give my permission to the physician elected by the adult swim coach to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult).

Signature of parent or guardian _____

Date: _____