

# Caldwell Swim Club Medical Card

Date \_\_\_\_\_

Swimmer Name \_\_\_\_\_

Address \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone No \_\_\_\_\_

Any Allergies \_\_\_\_\_ yes \_\_\_\_\_ no

If yes to Allergies, what are they

\_\_\_\_\_

Present Medications

\_\_\_\_\_

Authorization in case of an emergency to furnish treatment, if needed:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_