Medical History Record

Swimmer's name: _____DOB: Y/M/D:_____

BC Care Card Number: _____

Parent/Guardian name: _____

Address: _____

Home phone: _____cell: _____

Parent/Guardian name: _____

Address: (if different) _____

Home phone: (if different) _____cell: _____

Alternate Contact Person: _____

Home phone: _____cell: _____

Record of Illness	Medication	Notes
Allergies (Food/Medication)		
Asthma		
Blackouts		
Chest Pains		
Diabetes		
Heart Disease		
Reoccurring Headaches		
Seizures		
Other		

Please use this space for any additional notes:

All information is confidential and will only be used in the event of an emergency.