



**MEDICAL INFORMATION FORM**

*To be completed by swimmers who are 18 or over or by parent/carer if swimmer is under 18.*

Name of Swimmer: ..... Date of Birth: .....

The Disability Discrimination Act 2004 defines a disabled person as anyone with physical or mental impairment which has a substantial and long-term adverse effect on his/her ability to carry out normal day to day activities.

Do you consider the swimmer, named above, to have an impairment? YES / NO

If YES, what is the nature of the disability?

- |  |   |
|--|---|
| <input type="checkbox"/> Visual impairment   | <input type="checkbox"/> Physical disability    |
| <input type="checkbox"/> Hearing impairment  | <input type="checkbox"/> Multiple disability    |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Other (please specify) |

**Medical information:**

Please detail below any medical information that the Club needs to know, such as: allergies; asthma; epilepsy; orthopaedic problems; special dietary requirements etc

.....  
.....

Name, address and telephone number of swimmer’s doctor: .....

.....

The information provided will be disclosed only to those members of the Club for whom it is appropriate, and to relevant officers of the Amateur Swimming Association and British Swimming.

I understand that, in compliance with the Data Protection Act 1998, Shrewsbury ASC will ensure that the information I have provided will be securely kept and will be shredded once the swimmer is no longer a member of Shrewsbury ASC. I will make every effort to ensure that the medical information provided is kept up-to-date.

**For parents/carers of swimmers under 18:**

It may become essential for the Club Coach or Team Manager to have the necessary authority to obtain any urgent treatment which may be required whilst at a competition with Shrewsbury ASC. Would you please therefore sign below to give your consent.

I, ....., the parent/carer of the above named swimmer, hereby give permission for the Coach or Team Manager to give the immediate necessary authority on my behalf for any medical or surgical treatment recommended by competent medical authorities, where it would be contrary to the swimmer’s interest, in the doctor’s medical opinion, for any delay to be incurred by seeking my personal consent.

Signed: (Parent/Carer if swimmer is under 18) ..... Date: .....

Please PRINT Your Name: .....

*After completion, please hand in to a Swimming Coach or Squad Rep in an envelope marked for the attention of “The Membership Secretary”.*

