BLUE LAKE Y SWIM CLUB
SWIMMER REGISTRATION & MEDICAL INFORMATION FORM 2019/2020

SWIMMERS DETAILS					
FULL NAME					
ADDRESS					
SUBURB					
DATE OF BIRTH					
SWIM SA REGISTRATION NO.		DATE OF REGISTRATION			

SWIMMER MEDCIAL DETAILS				
MEDICARE NUMBER		EXPIRY DATE		
PRIVATE HEALTH INSURANCE	FUND NAME		MEMBER NO.	
	TABLE			
AMBULANCE COVER	YES /NO	MEMBERSHIP NO.		
FAMILY DOCTORS NAME				
CLINIC NAME		PHONE NO.		

PARENT/GUARDIAN CONTACT DETAILS TO BE COMPLETED IF SWIMMER UNDER 18 YEARS OF AGE			
NAME 1ST PARENT/GUARDIAN			
ADDRESS			
EMAIL 1		EMAIL 2	
HOME PH NO.		WORK PH NO.	
MOBILE NO.		SWIM SA MEMBER	YES /NO
NAME 2ND PARENT/GUARDIAN			
ADDRESS			
EMAIL 1		EMAIL 2	
HOME PH NO.		WORK PH NO.	
MOBILE NO.		SWIM SA MEMBER	YES /NO

EMERGENCY CONTACT IF NEITHER PARENT/GUARDIAN ARE AVAILABLE			
NAME			
PHONE NO. 1		PHONE NO. 2	
RELATIONSHIP TO CHILD			

PERMISSION FOR USE OF CHILDS NAME OR IMAGE FOR PROMOTION OF CLUB

From time to time, the Club seeks to promote itself to the wider public and this may entail the use of photographs in the print media or footage on the electronic media or even our Website.

Do you give permission for your child to be photographed/have video footage taken/included on the Club's Website?

Print Media	**YES / NO**
Electronic Media	**YES / NO**
Website	**YES / NO**

SIGNED: _____ (Parent/Guardian 1 or Swimmer if 18 or over)

DATE: _____

SIGNED: _____ (Parent/Guardian 2 if under 18) DATE: _____

PLEASE COMPLETE THE MEDICAL INFORMATION ON THE BACK OF THIS FORM

BLUE LAKE Y SWIM CLUB
SWIMMER REGISTRATION & MEDICAL INFORMATION FORM 2019-2020

SWIMMER MEDICAL DETAILS

Please tick if the swimmer suffers any of the following:

☐ Allergies	☐ Blood Pressure	☐ Epilepsy	☐ Hay Fever	☐ Nose Bleeds
☐ Asthma	☐ Diabetes	☐ Fainting	☐ Eczema	☐ Headaches
☐ Reaction to Drugs	☐ Fits or Blackouts	☐ Heart Condition	☐ Other	

If YES to allergies please list	
If YES to asthma please list treatment	
If YES to diabetes please list treatment	
If Yes to epilepsy please list treatment	
If Yes to any others please give further details	
Date of Last TETANUS injection	
If the swimmer is on any medication please list (name, dose, frequency, route, possible side effects)	
If aware of any medical emergency that could occur please expand on treatment required to prevent and treat. Attach treatment plan if applicable	
Please expand on any other relevant information relating to the health of the swimmer if applicable	

PERMISSION FOR ATTAINMENT OF TREATMENT

Should it be necessary for our/my child to have medical, dental or optical treatment whilst participating in some aspect of the Club swimming program and we/I cannot be contacted or advised, permission is given for the Coach or Team Manager or Committee Member to use their judgment in obtaining the best possible service required.

We/I understand that any insurance costs incurred will be our/my responsibility.

We/I understand that any medical costs incurred will be our/my responsibility.

If there is any change in our/my child medical condition it is our/my responsibility to notify the Club and update the Medical Information Form and treatment plan

SIGNED: _____ (Parent/Guardian One or Swimmer if 18 or over)

DATE: _____

SIGNED: _____ (Parent/Guardian Two) DATE: _____

☐ **I have accepted the conditions of the BLY Pick Up Drop Off Policy** *(please tick)*

Payment Plan – Please see the BLY Treasurer if a payment plan is needed to pay for seasonal fees.