SWALLOW SCHOOL DISTRICT
INSPIRING EXCELLENCE SINCE 1844

Swallow School District Athletic Form

Name:	
Date of Birth:	
Address:	
Parent Phone Number(s):	
Personal Physician:	
Physician Phone:	

EMERGENCY CONTACT INFORMATION	
Emergency Contact Name:	
Phone Number (with area code)	

Has your doctor ever denied or restricted your participation in sports for any reason?	❑ Yes	❑ No
Do you have any ongoing medical condition (like diabetes or asthma)?	❑ Yes	❑ No
Are you currently taking any prescription or non prescription (OTC) medicines or pills?	❑ Yes	❑ No
Do you have any known allergies?	❑ Yes	❑ No
Have you ever passed out or nearly passed out **during** exercising?	❑ Yes	❑ No
Have you ever passed out or nearly passed out **after** exercising?	❑ Yes	❑ No
Do you cough, wheeze, or have difficulty breathing during or after exercise?	❑ Yes	❑ No
Have you ever had a need to use an inhaler or take asthma medication?	❑ Yes	❑ No
Do you have any problems with bones, joints, ligaments, or tendons?	❑ Yes	❑ No
Do you have any heart related problems, defects, or symptoms?	❑ Yes	❑ No

Parent Signature:	Date: