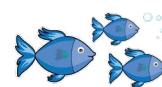


Medical Information

Little Flipper Swim School LLC



LITTLE FLIPPERS
Swim School

STUDENT INFORMATION

STUDENTS NAME _____ AGE _____ YRS _____ MO _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

CELL NUMBER _____ EMAIL _____

MOTHERS NAME _____ FATHERS NAME _____

STUDENT MEDICAL INFORMATION

GENDER ☐ Male ☐ Female ☐ Other

PEDIATRICIANS NAME _____

PLEASE ANSWER THE FOLLOWING (CHECK YES OR NO) (IF YES EXPLAIN PLEASE ON THE BACK)

Y N

- ☐ ☐ Seen by medical specialist
- ☐ ☐ Bowel or Bladder problems
- ☐ ☐ Surgery
- ☐ ☐ Heart Murmur or defect
- ☐ ☐ Allergies
- ☐ ☐ Gastro-esophageal Reflux

Y N

- ☐ ☐ CPR
- ☐ ☐ Chronic Illness
- ☐ ☐ Head injury/loss of consciousness
- ☐ ☐ Fever for longer than a week
- ☐ ☐ A.D.D./autistic spectrum
- ☐ ☐ Therapy OT PT Speech Other

Y N

- ☐ ☐ Seizures
- ☐ ☐ Lactose Intolerance
- ☐ ☐ Asthma
- ☐ ☐ Respiratory problems
- ☐ ☐ Ear Infections
- ☐ ☐ Ears Tubes

Explanation _____

STUDENT AQUATIC HISTORY

Family has or vacations near (check if applicable)

☐ Pool ☐ Hot tub ☐ Pond/Tank ☐ Lake ☐ Canal ☐ Ocean ☐ Boat ☐ Other

Previous aquatic Instruction if any

Program Type _____ Where _____ When _____

Are parents/guardians aquatically skilled? ☐ Yes ☐ No

Has your child ever used a floatation device? ☐ Yes ☐ No Type of Device _____ How long? _____

Has your child ever had an aquatic accident? ☐ Yes ☐ No If yes, explain _____