# 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 | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Seen by medical specialist | ☐ | ☐ | CPR | ☐ | ☐ | Seizures |
| ☐ | ☐ | Bowel or Bladder problems | ☐ | ☐ | Chronic Illness | ☐ | ☐ | Lactose Intolerance |
| ☐ | ☐ | Surgery | ☐ | ☐ | Head injury/loss of consciousness | ☐ | ☐ | Asthma |
| ☐ | ☐ | Heart Murmur or defect | ☐ | ☐ | Fever for longer than a week | ☐ | ☐ | Respiratory problems |
| ☐ | ☐ | Allergies | ☐ | ☐ | A.D.D./autistic spectrum | ☐ | ☐ | Ear Infections |
| ☐ | ☐ | Gastro-esophageal Reflux | ☐ | ☐ | Therapy OT PT Speech Other | ☐ | ☐ | 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 _____